Domestic Homicide Review

Angela

2021

Overview Report

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Commissioned by:	Kent Community Safety Partnership
	Medway Community Safety Partnership
Review completed:	28th June 2023

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1.1 Angela is described by her sister and her ex-partner, Joseph, as being a fun person who was very outgoing. She would always make a big joke of things and was someone who did not want any responsibility. They described her as a “female Peter Pan”, someone who never grew up. They will miss her greatly.

1.2 The panel wish to send their sincere condolences to the family and friends of Angela for their loss.

2 Timescales

2.1 This overview report has been commissioned by the Kent Community Safety Partnership (on behalf of the local CSPs including the Medway Community Safety Partnership) and the Kent and Medway Safeguarding Adults Board concerning the death of Angela which occurred in June 2021.

2.2 It is important to understand what happened in this case at the time, to examine the professionals’ perspective at that time, although it is likely as a consequence that hindsight will be encountered. This will be rationalised by taking key matters forward in order to broaden professionals’ awareness both for the future and to ensure that best and current practice is embedded and that any learning is maximised both locally and nationally.

2.3 Family members were contacted and asked whether they would like to see a copy of the Terms of Reference and invited to contribute to the review and comment. The family were liaised with at different stages of the review process and updated on the panel meetings. At the conclusion of the review process, Angela’s family were contacted regarding reviewing the overview report, its recommendations and speaking to the report writer. Angela’s ex-partner and father of her child was also contacted and asked if he would like to be part of the review process. Angela’s sister and her ex-partner, Joseph were spoken to regarding Angela.

2.4 Pseudonyms for both Angela and the male she was in a short relationship with, Anthony, have been used throughout this report to maintain anonymity. Angela's ex-partner has also been given a pseudonym. These pseudonyms were shared with the family who agreed with the names used.

2.5 The Home Office were notified by the Community Safety Partnership (CSP) of their intention to carry out a Domestic Homicide Review (DHR). The Coroner was also notified that a Domestic Homicide Review was taking place.

2.6 In accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004, a Kent and Medway Domestic Homicide Review (DHR) Core Panel meeting was held on 14th July 2021. After more information was provided in respect of Angela's recent relationship and suspected perpetrator, a virtual decision was made that the death of Angela met the criteria for a DHR on the 4th August 2021, and this review was conducted using the DHR methodology. That agreement was ratified by the Chair of the Kent Community Safety Partnership.

2.7 A "Domestic Homicide Review" means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by;

(a) a person of who he/she was related or with whom he/she was or had been in an intimate personal relationship, or
(b) a member of the same household as himself/herself, held with a view to identifying the lessons to be learnt from the death.

2.8 The Kent and Medway Domestic Homicide Review Panel paid due regard to the guidance within the 2016 publication which states;

Where a victim took their own life (suicide) and the circumstances give rise to concern, for example it emerges that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable.

2.9 The DHR was started in September 2021, when the first meeting took place, and concluded in March 2023. The panel met on five occasions, where they identified the key learnings, set the terms of reference, examined Independent Management Reviews (IMRs) and agency information, and scrutinised the overview report and its recommendations. The review process was paused for a month due to the pandemic and the additional pressures placed upon agencies. At the first panel meeting in September a decision was made that due to the additional pressures agencies would be given extra time to complete their IMRs. Upon completion of the overview report an action plan was developed and fully populated by panel members prior to Home Office submission.

2.10 The Coroner's inquest into Angela's death took place with the verdict being recorded as suicide.

3 Confidentiality

3.1 The findings of the Domestic Homicide Review are confidential. At the beginning of the meetings of the review panel, attendees were reminded of the confidentiality agreement. All panel meetings took place over Microsoft Teams. The information supplied throughout the review process was only available to those participating in the review and their line managers. This overview report remains confidential until approval to publish is given by the Home Office Quality Assurance Panel. Dissemination is addressed in section 12 below.

3.2 The deceased in this case was a white female of British nationality. Angela was in her 30s at the time of her death. The male Anthony, who she was in a very short-term relationship with, is a white male of British nationality. Anthony was in his late 20s at the time of Angela's death. Angela left behind one child from a previous relationship. The child was living with their father at the time of Angela's death.

3.3 Pseudonyms used for the overview report:

Name	Gender	Relationship	Ethnic Origin
Angela	Female	Deceased	White British
Joseph	Male	Ex-partner/father of baby	White British
'Baby'	N/A	Baby of Angela and Joseph	White British
'Sister'	Female	Sister of Angela	White British
Anthony	Male	Short term relationship with Angela	White British

4 Methodology

4.1 The purpose of this overview report is to:

- ensure that the review is conducted according to good practice, with effective analysis and conclusions of the information related to the case.

- establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic abuse including their dependent children.

- identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on and what is expected to change as a result.

- apply these lessons to service responses including changes to policies and procedures as appropriate to prevent domestic homicide and improve service responses for all domestic abuse victims and their children through improved intra and inter-agency working.

4.2 This overview report has been compiled with reference to the comprehensive Independent Management Reviews (IMRs) prepared by authors from the key agencies involved in this case. Each author is independent of the victim, the family and management responsibility for practitioners and professionals

involved in this case. IMRs were signed off by a Senior Manager of that organisation before being submitted to the Domestic Homicide Review Panel. Where IMRs have not been required, reports from other agencies or professionals have been received as part of the review process.

4.3 The overview report author has also fulfilled a dual role and has chaired the panel meetings in respect of this case. This is recognised as good practice and has ensured a continuity of guidance and context for the review. There have been a number of useful professional discussions arising and the panel meetings have been referenced and noted appropriately for transparency.

4.4 The review author has also made several requests to agencies and individuals for clarity of issues arising and is grateful for the participation of individuals and agencies throughout. The professionalism of the panel members and the overall quality of the responses has been of a high standard.

4.5 Some of the information within the report will not be, where possible, personally referenced, and the author has due regard for any confidentiality and sensitivities required. The author has also sought additional information outside of the date parameters and this has assisted in context to examine some background history.

4.6 It is important that this Domestic Homicide Review has due regard to the legislation concerning what constitutes domestic abuse which is defined as:

Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members, regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: psychological, physical, sexual, financial and emotional.

4.7 The government definition also outlines the following:

Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

Controlling behaviour is a range of acts designed to make a person subordinate and/or dependant by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour

4.8 Section 76 of the Serious Crime Act 2015 created a new offence of controlling or coercive behaviour in an intimate or family relationship. Prior to the introduction of this offence, case law indicated the difficulty in proving a pattern of behaviour amounting to harassment within an intimate relationship. The new offence, which does not have retrospective effect, came into force on 29th December 2015.

4.9 One of the purposes of a Domestic Homicide Review (DHR) is to give the most accurate possible account of what originally transpired in an agency's response to Angela, to evaluate it fairly, and if necessary, to identify any improvements for future practice.

5 Terms of Reference

The critical dates for this review have been designated by the panel as March 2020 to the date of Angela's death. However, the panel also agreed to review Anthony's involvement with agencies from 2018 onwards. The Chair also asked the agencies providing IMRs to be cognisant of any issues of relevance outside of those parameters which will add context and value to the report. These dates were felt to be the most relevant in the life of Angela as it was during this time that the domestic abuse, her health and wellbeing was most evident. The timescales were again reviewed by the panel and were still felt to be appropriate.

5.1 The Focus of the DHR

5.1.1 In conducting the Domestic Homicide Review into the death of Angela, the Panel had regard to:

5.1.1.1 Establishing whether any agencies identified possible and/or actual domestic abuse that may have been relevant to the death of Angela.

5.1.1.2 If such abuse took place and was not identified, considering why not, and how such abuse can be identified in future cases.

5.1.1.3 If domestic abuse was identified, were the agency responses in accordance with their own and multi-agency policies, protocols, and procedures in existence at the time.

5.1.1.4 If domestic abuse was identified, the review will examine the method used to identify risk and the action plan put in place to reduce that risk. The review will examine how the pattern of domestic abuse was recorded and what information was shared with other agencies.

5.1.1.5 This review will also consider current legislation and good practice.

5.2 Specific Issues to be Addressed

5.2.1 Specific issues that must be considered, and if relevant, addressed by each agency in their IMR were:

5.2.1.1 Were practitioners sensitive to the needs of Angela, knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

5.2.1.2 Did the agency have policies and procedures for Domestic Abuse, Stalking and Harassment (DASH) risk assessment and risk management for domestic abuse victims of perpetrators, and were those assessments correctly used in the case of

Angela and Anthony? Did the agency have policies and procedures in place for dealing with concerns about domestic abuse? Were these assessment tools, procedures and policies professionally accepted as being effective? Was Angela and/or Anthony subject to a MARAC or other multi-agency forums?

5.2.1.3 Did the agency comply with domestic violence and abuse protocols agreed with other agencies, including any information sharing protocols?

5.2.1.4 What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?

5.2.1.5 Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?

5.2.1.6 When, and in what way, were Angela's wishes, and feelings ascertained and considered? Is it reasonable to assume that the wishes of the Angela should have been known? Was Angela informed of options/choices to make informed decisions? Were they signposted to other agencies?

5.2.1.7 Was anything known about Anthony? For example, were they being managed under MAPPA? Were there any injunctions or protection orders that were, or previously had been, in place? Were there previous incidences of DA with other partners that should have been considered?

5.2.1.8 Had Angela disclosed to any practitioners or professionals and, if so, was the response appropriate?

5.2.1.9 Was this information recorded and shared, where appropriate? Was there an emphasis on self-reporting or was information shared appropriately between agencies?

5.2.1.10 Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary? Were any of the other protected characteristics relevant in this case?

5.2.1.11 Were senior managers or other agencies and professionals involved at the appropriate points?

5.2.1.12 Are there other questions that may be appropriate and could add to the content of the case? Was there a history of self-harming or suicidal ideation linked to Angela?

5.2.1.13 Are there ways of working effectively that could be passed on to other organisations or individuals?

5.2.1.14 Are there lessons to be learned from this case relating to the way in which agencies worked to safeguard Angela and her child, and promote their welfare, or the way it identifies, assesses and manages the risks posed by Anthony? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?

5.2.1.15 Did any staff make use of available training?

5.2.1.16 Did any restructuring take place during the period under review which had an impact on the quality of the service delivered?

5.2.1.17 How accessible were services to Angela?

5.2.1.18 Angela recently gave birth to a baby who was born prematurely. The baby was living with their birth father and Angela was only allowed supervised access. The baby was under a Child Protection Plan. What impact did this have on Angela? Was a whole family approach considered?

5.2.1.19 What impact did Angela's alcohol dependency have upon her relationship with professionals and was this dealt with in a consistent manner?

5.2.1.20 Were there any identified mental health considerations surrounding Angela and any previous incidents of self-harm or suicide attempts/ideation? Was the Mental Capacity Act (MCA) considered and applied to Angela and Anthony?

5.2.1.21 What considerations did agencies make regarding Angela being homeless and the placing of her in a hostel with identified health and support issues? Were any issues of vulnerability identified regarding Angela and Anthony in relation to placing them into a mixed hostel? Were the appropriate risk assessments completed regarding Angela and Anthony when placing them into the hostel?

5.2.1.22 Were agencies aware of any care and support needs surrounding Angela and Anthony as individuals, and if so was the appropriate level of support in place? Were the appropriate referrals made? Was there a good understanding of the thresholds for professionals in relation to referring Angela and Anthony for any safeguarding concerns?

5.2.1.23 Was the Violence Against Women and Girls agenda identified and were agencies open regarding the relationship that Angela and Anthony formed?

5.2.1.24 Did practitioners understand how and when domestic abuse aligns with statutory adult safeguarding?

5.2.1.25 Did practitioners understand alcohol misuse and self-neglect and how these fit with adult safeguarding?

5.2.1.26 Do practitioners understand how care and support needs form vulnerability?

5.2.1.27 Were there clear lines of accountability in terms of support needs – did everyone know what each other was doing? (Multi-agency working)

5.2.1.28 Had the perpetrator abused partner/s or a family member before?

5.2.1.29 Was the perpetrator known to agencies as an abuser?

5.2.1.30 Has the perpetrator any previous relevant offending history?

5.2.1.31 Was the perpetrator being managed or supervised by, or attending any of the following; MAPPA, Probation, Mental Health Services, Drug and Alcohol Services, attending or had attended a perpetrator programme?

5.2.1.32 Was any good practice identified within agencies to help develop future practice?

6 Involvement of Family Members and Friends

6.1 Unexpected deaths are tragic, not just for the family, but for friends and work colleagues alike. The overwhelming effect that this has on those individuals can endure and their privacy must be respected and any willingness to assist agencies must be of their own volition. It is acknowledged by the review that they are survivors of this tragic episode, not least the family of the deceased, and this review must be seen as a way forward in supporting others who may have similar needs and obtaining individual and sometimes personal views, may identify intervention opportunities for agencies in future cases.

6.2 Joseph and Angela's sister were contacted by the Chair who explained the review process and asked them if they wished to be involved with the review process. Initial contact with the family included the Home Office DHR information leaflet and the Chair also informed the family of support available from Advocacy After Fatal Domestic Abuse (AAFDA). The Terms of Reference were shared, together with information regarding support that was available for families who have been bereaved through suicide. The family indicated that they were happy with the Terms of Reference and did not want to add anything further. The family were kept updated throughout the review process and asked as to whether they wished to meet the review panel, which they declined. Angela's sister and ex-partner, Joseph, kindly agreed to speak to the Chair. A decision was made that it would be inappropriate to speak to Anthony regarding the review process due to the very short length of time that he was in a relationship with Angela. Angela's sister and Joseph also expressed their views that they did not wish Anthony to be spoken to. Angela's sister reviewed and agreed the final version of the Overview Report on 23rd June 2023 when she met with the Independent Chair for their final meeting.

6.3 It was described that Angela was only 14 years of age when her mother died and this impacted on her greatly. Her father started a new relationship and his partner bought Angela, then 16, and her other daughter a plane ticket for Spain. Angela went on the holiday to Spain and decided that she liked it so much that she would stay. Angela's sister stated that Angela had started drinking after the death of their mother but this appeared to get worse due to the lifestyle she lived in Spain. Angela started a relationship with a much older man who appeared to be a good influence on her. He tried to support her and encouraged her to stop her drinking. Sadly, Angela's partner suffered a heart attack in front of Angela and died. As a result, of this it appears that Angela turned to alcohol as a coping mechanism. Angela had a serious accident whilst in Spain and ended up lodging in someone's house. Angela's sister went over to Spain and after finding her in such a bad way brought her back to England where she stayed with her for a while.

6.4 It was described by Angela's sister that Angela tried really hard to stop drinking and tried to get help but that she found it too difficult to stop. She said that she also spoke to professionals to try and get help for Angela and her drinking but was always told that as Angela was over 18, she could make

her own decisions and that she had to ask for help herself. Angela's sister stated that she found it very frustrating that professionals would not listen to her when she asked for help and that Angela was too poorly to ask for help herself. She felt that she was let down by agencies and was left to cope with someone who was very ill on her own.

6.5 Angela's sister described Angela as being two different people when she drank. When under the influence of alcohol, she would become overly friendly and excitable but when she was not drinking she would be quiet and would appear to be depressed.

6.6 They described that after the birth of her baby, Angela would try to spend as much time with her baby as she could. They said she found it very difficult and struggled on occasions to cope as the baby was in hospital for a long time, and it was difficult to find the money to travel to see them. The journey was long and Angela and Joseph needed to get multiple buses to reach the hospital. They described Angela as making a real effort and that she spent as much time with the baby as she could. They said that when Angela drank she always did it when she was away from the baby, when she knew that she was not caring for them.

6.7 Angela's sister and Joseph both described the baby coming home as also being very difficult and were very critical of the level of support that was offered to Angela, though they spoke very highly of the Health Visitor (HV) who they stated went over and above her responsibilities to try and help them stay together as a family.

6.8 Angela's sister stated that she made several calls to the baby's social worker to ask for additional help for Angela but that she was not listened to. Joseph and Angela's sister knew that she was continuing to misuse alcohol but they believed that she was trying to get some help. They were told by Angela that she was working with Change Grow Live (CGL), alcohol services to support her in stopping drinking, and they were shocked when it was identified that she had not been working with the service. They feel that Angela was probably telling them things to stop them worrying and to look as if she was engaging with support services.

6.9 They described Integrated Children's Services as being very supportive over the baby but also as being very dismissive over Angela. They stated that Angela was told that she had to leave the home address due to her drinking and that if she did not she would have the baby taken from her. They stated that there was no support offered to them as a family to help Angela keep the baby with her and that they were very dismissive of her. It appears that Angela was told on numerous occasions that if she did not want the responsibility of the baby then she just needed to say and they would take them into care.

6.10 A day after leaving the family home and leaving her baby with family members, Angela was due to have a supervised visit. When she did not arrive Joseph tried contacting her and her phone was answered by a male. The male told Joseph that Angela was at the railway station and that she was very drunk and upset. Joseph attended the station and they had a row as he was concerned that the baby would be taken from Angela permanently and that he also might lose custody. The British Transport Police (BTP) attended the station and Joseph went home to care for the baby. It was identified that the BTP took Angela to the local hospital and left her outside. It appears that she slept on a bench directly outside the hospital all night before going into the waiting room at 9am the next morning, stating that she had taken an overdose of medication. It appears the medication was Joseph's, which she had taken without him knowing.

6.11 Angela's sister felt that Angela was given very little support after the overdose apart from being given anti-depressants. She stated that whilst Angela was at the hospital she was contacted by the baby's social worker asking if Angela could go to live with her for a while. Angela's sister stated that she agreed as she felt that she had no choice. She stated that she did not have much room in her house and that her children had to share a bedroom so that Angela could have a room. She stated that she was told it would only be for about a week but in fact was about eight/nine weeks. She said that during the time of living with her that Angela was still using alcohol to help her cope, but that although she was involved with the baby's social worker she did not have any support for herself. Angela was not offered any accommodation and they

believed that she was just left to get on with it. They feel strongly that Angela should have been offered additional support in how she could care for her baby. They expressed feeling that the social worker was only concerned with the baby and that they were safe and was not looking at how they could make them a family unit again.

6.12 Angela's sister describes her husband taking Angela to the housing department so that she could register as being homeless. It appears that whilst she was dropped outside she disappeared and became drunk and took some medication. Angela was taken to hospital where she was treated. The sister received a call from Angela at 1am the next morning stating that she had been released from hospital and had nowhere to go. Angela was picked up and stayed with her sister for another three weeks.

6.13 Angela's sister and Joseph described how happy Angela was to be given a place at Hostel B. She believed that it would be a new start for her and that she would get the help and support she needed. She was really positive about the move. Angela's sister took her to the hostel to meet the support worker in charge to go through Angela's background and to talk though the support they could offer her. They were informed that alcohol and drugs were not allowed on the premises and that there was a counsellor available.

6.14 The family state that unfortunately Angela disconnected from them shortly after she moved into the hostel and they later found out that she had started a relationship with Anthony. Joseph stated that Angela was only living at the hostel for a couple of weeks and during that time she had to spend five days in hospital due to a burst cyst.

6.15 Joseph stated that Angela informed him about the relationship with Anthony. She told him that she had had sex with Anthony on two occasions and that he had started to follow her around like a lap dog and that he would not leave her alone. He stated that they had talked through what had happened and that they were trying to work together to find a way to look after their baby together.

6.16 Joseph described Angela as being someone that was not happy on her own and needed to get comfort from someone and that she would always find someone who would look after her. He stated that she was a very vulnerable person who needed people to help her and that she needed additional help and support.

6.17 Both Joseph and Angela's sister stated that they strongly believed that all the support was focused too much on the baby and limited support was given to Angela. They stated that Angela did not have her own social worker and that she had received limited support from the mental health team. They said that Angela did not receive any support after the second incident where she had overdosed on tablets and that she was just released from hospital. Angela's sister stated that the professionals all appeared to take Angela's word that she was okay and that they would not listen to her when she tried to tell them that she was not. She described telling professionals that Angela was suffering night terrors, was not sleeping and was depressed but they would just accept Angela's word that she was fine without any follow up.

6.18 **Anthony**

6.18.1 Anthony was diagnosed as having type 1 diabetes mellitus in 2012. The Rough Sleeper Team had numerous intermittent contacts with Anthony between October 2017 and November 2019. Kent Police have identified that Anthony has issues around relationships particularly when they fail, which led to previous allegations of harassment by both parties.

6.18.2 Anthony moved into Hostel B in September 2019. At the time that he was referred he was presenting with multiple support needs including substance misuse and physical health issues linked to diabetes. During his time at Hostel B Anthony made numerous suicide attempts which resulted in hospital treatment. Anthony also had numerous interactions with the criminal justice system mainly linked to theft. Anthony had a probation worker and his hostel key worker was aware of his criminal history.

6.18.3 The staff at Hostel B were made aware whilst Anthony was living there of two incidents of a sexual nature against females. Although these incidents were recorded within the risk assessment there does not appear to have been a re-assessment of risk.

6.18.4 Anthony had presented to the hospital emergency department on five occasions with either overdoses or suicide ideation. On three of these occasions it was noted that he was referred to the Psychiatry Liaison Services run by Kent and Medway NHS and Social Care Partnership Trust (KMPT). Anthony had also presented at the emergency department on two occasions having either punched a wall or kicked a TV. He had fractured his hand on one of these occasions.

6.18.5 Anthony and Angela had only known each other for a very short period of time, and it appears that they could only have been in a relationship for eight days, at the most.

7 Contributors to the Review

7.1 Independent Management Reviews (IMRs) were written by a member of staff from the organisation to which it relates. Each of the agency authors is independent of any involvement in the case including management or supervisory responsibility for the practitioners involved. The IMRs were quality assured by supervisors and were signed off by management prior to being presented to the panel.

7.2 Each of the following organisations contributed to the review:

Agency/Contributor	Nature of Contribution
Kent Police	Independent Management Review
Kent County Council Integrated Children's Services	Independent Management Review
Kent County Council Adult Social Care	Independent Management Review
Borough Council A, Housing	Independent Management Review

Look Ahead, Hostel B	Independent Management Review
We Are With You	Independent Management Review
Porchlight	Summary Report
Kent & Medway Clinical Commissioning Group (Integrated Care Board)	Independent Management Review
Maidstone & Tunbridge Wells NHS Trust	Independent Management Review
Kent Community Health NHS Foundation Trust	Independent Management Review
Kent & Medway NHS and Social Care Partnership Trust	Independent Management Review
Medway NHS Foundation Trust	Summary Report

8 Review Panel Members

8.1 The Review Panel was made up of an Independent Chair and senior representatives of organisations that had any relevant contact with Angela and/or Anthony. It also included a senior member of the Kent Community Safety Unit and an independent advisor from a Kent-based domestic abuse service.

8.2 The members of the panel were:

Name	Organisation	Job Role
Elizabeth Hanlon		Independent Chair and Report Writer
Kathleen Dardry	Kent County Council, Community Safety	Practice Development Officer
Victoria Widden	Kent & Medway Safeguarding Adults Board	Safeguarding Adults Review Manager
Matthew Basford	Kent Police	Detective Chief Inspector
Sophie Baker	KCC Integrated Children's Services	Practice Development Manager
Catherine Collins	KCC Adult Social Care	Adult Strategic Safeguarding Manager
Tracey Creaton	Kent & Medway CCG (Integrated Care Board ICB)	Designate Nurse for Adult Safeguarding
Bridget Fordham	Medway NHS Foundation Trust	Head of Safeguarding

Auxilia Muganiwah	Kent & Medway NHS and Social Care Partnership Trust	Specialist Safeguarding Advisor
Karen Davies	Maidstone & Tunbridge Wells NHS Trust	Named Nurse for Safeguarding Adults
Annie Readshaw	Kent Community Health NHS Foundation Trust	Named Nurse Safeguarding Children
Mike Bansback	Look Ahead, Hostel B	Head of Safeguarding and Quality
Hannah Willis	We Are With You	Head of Mental Health Service Delivery
Claire Keeling	Borough Council A, Housing	Housing Solutions Manager
Yvette Hazelden	Look Ahead *(Domestic Abuse Specialist)*	Strategic and Development Lead
Tim Woodhouse	Kent County Council, Suicide Prevention *(Suicide Expert Opinion)*	Suicide Prevention Project Support Officer
Symon Hewish/Satinder Kang	Change Grow Live *(Substance Misuse Expert Opinion)*	Locality Lead
Charlie Grundon	Porchlight	Safeguarding Lead

9 Chair and Overview Report Writer

9.1 The Independent Chair and report writer for this review is Elizabeth Hanlon, who is independent of the Community Safety Partnership and all agencies associated with this overview report. She is a former (retired) senior police detective from Hertfordshire Constabulary, having retired seven years ago, who has several years' experience of partnership working and involvement with several previous Domestic Homicide Reviews, Partnership Reviews and Serious Case Reviews. She has written several Domestic Homicide Reviews for Hertfordshire, Cambridgeshire, and Essex County Council.

9.2 The Chair has received training in the writing of DHRs and has completed the Home Office online training and online seminars. She also has an enhanced knowledge of Domestic Abuse and attends the yearly Domestic Abuse conferences held in Hertfordshire and holds regular meetings with the Chair of the Domestic Abuse Partnership Board in Hertfordshire to share learnings across boards. She is also the current Independent Chair for the Hertfordshire Safeguarding Adults Board.

10 Other Reviews/Investigations

10.1 A Coroner's Inquest was held into the death of Angela in September 2021. The Assistant Coroner recorded the cause of death as a suicide.

10.2 The allegation of rape reported to police by Angela was subject to an investigation, but no prosecution took place.

10.3 Angela's death was referred to the Kent and Medway Safeguarding Adults Board (KMSAB) for a decision to be made as to whether it fitted the criteria for a Safeguarding Adults Review (SAR). It was identified that the criteria for a SAR was met, however, it was considered duplicative to undertake both a SAR and a DHR and therefore it was agreed that a joint review would be undertaken. The DHR Terms of Reference were therefore added to by the KMSAB to include any learning surrounding Angela's care and support needs. The review panel members were made up of representatives of both the KMSAB and other agencies and the report will be made available on the Board's website and the adult safeguarding learning will be progressed by the Board.

10.4 A Serious Incident Review took place by Look Ahead following the death of Angela. The findings from the review were incorporated within Look Ahead's Independent Management Review.

11 Equality and Diversity

The Panel considered the nine protected Characteristics under the Equality Act 2010, (age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership and pregnancy and maternity). They sought to establish if they were applicable to the circumstances of the case and had any relevance in terms of the provision of services by agencies or had in any way acted as a barrier. The protected Characteristics identified below are highlighted discussed throughout the overview report.

11.1 **Sex**

11.1.1 There is extensive research to support that in the context of domestic violence, females are at a greater risk of being victimised, injured, or killed. In fact, the term “Femicide”, which refers to the killing of women by men because they are women, was coined in the 1970s to raise awareness of the violent deaths of women.

11.1.2 The United Nations defines gender-based violence in the following way:

“The definition of discrimination includes gender-based violence, that is, violence that is directed against a woman because she is a woman or that affects women disproportionately. It includes acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty”

11.1.3 Whilst both men and women may experience incidents of inter-personal violence and abuse, women are considerably more likely to experience repeated and severe forms of abuse, including sexual violence. They are also more likely to have experienced sustained physical, psychological or emotional abuse, or violence which results in injury or death.

11.1.4 There are important differences between male violence against women and female violence against men, namely the amount, severity and impact. Women experience higher rates of repeated victimisation and are much more likely to be seriously hurt (Walby & Towers, 2017; Walby & Allen, 2004) or killed than male victims of domestic abuse. Further to that, women are more likely to experience higher levels of fear and are more likely to be subjected to coercive and controlling behaviours (Dobash & Dobash, 2004; Hester, 2013; Myhill, 2015; Myhill, 2017).

11.1.5 Domestic abuse perpetrated by men against women is rooted in women’s unequal status in society and is part of the wider social problem of male violence against women and girls. Research with the

University of Bristol showed that sexism and misogyny set the scene for male abusive partners' coercive and controlling behaviours. Sexism and misogyny serve to excuse abusive behaviour by men in intimate relationships with women and put up barriers to female survivors being believed and supported to leave abusive men (Women's Aid et al, 2021)[1].

11.1.6 During the review it was identified that during Angela's relationship with Anthony he acted in a controlling manner towards her. The relationship became very intense, very quickly and Angela commented to her ex-partner that Anthony wouldn't leave her alone, following her around and constantly sending her text messages.

11.2 Substance Misuse

11.2.1 Not all domestic abuse perpetrators use substances and not all people who use substances perpetrate domestic abuse. A case analysis of domestic homicide reviews found that substance use was a common feature of both intimate partner and adult family murders[2]. Recent findings by Gilchrist et al (2017) have also shown that domestic abuse perpetration is common amongst men attending treatment for substance use in England.

11.2.2 Where there is a relationship between substance use and consumption and violent behaviour, substance use and intoxication is no excuse. Many perpetrators are abusive without the use of substances so the cause of abuse cannot be related to substance use alone. Underlying issues such as power dynamics in the relationship, controlling behaviour and the normalisation of abuse, must also be considered when assessing substance use and domestic abuse perpetration.

[1] https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/domestic-abuse-is-a-gendered-crime/
[2] Sharp-Jeffs & Kelly 2016. http://repository.londonmet.ac.uk/1477/

11.2.3 Some victims may use substances during a relationship with their partner as a form of bonding, many others use substances post separation. For some victims of abuse, during times of turmoil, substances may be the only constant in their lives that they can depend on[3]. This was identified throughout the review in relation to Angela. Agencies did not always identify the impact that alcohol addiction had upon Angela's life and how much she struggles to control it. Alcohol appeared to be the fallback for Angela when things became too tough and she was identified as using it as a coping mechanism.

11.3 Mental Health

11.3.1 Angela is recorded as having mental health problems going back several years, mainly following the death of her mother. The Department of Health and Social Care published The Women's Mental Health Taskforce's final report in December 2018 where their findings showed that women are more likely to experience common mental health conditions than men, and while rates remain relatively stable in men, prevalence is increasing in women (McManus et al, 2016). Young women are a particularly high-risk group, with over a quarter (26%) experiencing a common mental disorder, such as anxiety or depression – almost three times more than young men (9.1%). Women described challenges in their experiences of mental health services, including problems building trusting relationships with staff, and a profound lack of voice or control. Those who had been in inpatient settings described a lack of ongoing support or aftercare, and a feeling of being "left to get on with it" when they left hospital.

11.3.2 The Taskforce heard that women's roles as mothers and carers was rarely considered in the support they received, with little provision to help them maintain relationships with their children and wider family. Women are sometimes reluctant to seek support in the first place for fear of having their children removed from their care, and for those who no longer had their children with them, the impact this had had on their mental health was frequently overlooked. Women with multiple needs,

[3] https://www.basw.co.uk/system/files/resources/substance-use-and-domestic-abuse-pocket-guide.pdf

many of whom have faced extensive violence, abuse, poverty and inequality, are often deeply traumatised and can face other challenges alongside poor mental health, such as addiction and homelessness. Yet the Taskforce heard that services are not always well set up to meet women's needs or be flexible to respond to where women are in their lives. Eating disorders, self-harm and suicide can also affect women and men differently. Eating disorders are more common among women and girls than men and boys, and young women and girls are more at risk of self-harm[4]. Although identified as having mental health issues and being alcohol dependent agencies failed to identify the impact alcohol had upon Angela's mental health and vice versa.

11.4 Maternity

11.4.1 Mental health remains one of the leading causes of maternal death during pregnancy and the first postnatal year. Maternal suicide is still the leading cause of direct (pregnancy-related) death in the year after pregnancy. Almost a quarter of all deaths of women during pregnancy or up to a year after the end of pregnancy were from mental health-related causes. It was felt that improvements in care might have made a difference in outcome for 67% of women who died by suicide[5].

11.4.2 There is also a societal expectation upon women to be caregivers and Martha Fineman[6] argues that "women's historical role in the family anchors them to that institution in ways that men's historic roles do not." Mothers are expected to protect children and any failure to measure up to this expectation can easily be construed as 'pathological", potentially leading to the removal of the children from the mother's care. Agencies failed to identify the significant impact of losing her child would have upon Angela and how this would affect her mental health.

[4] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/765821/The_Womens_Mental_Health_Taskforce_-_final_report1.pdf
[5] https://maternalmentalhealthalliance.org/news/mbrrace-suicide-leading-cause-maternal-death/
[6] Fineman, Martha Albertson, Feminist Theory in Law: The Difference It Makes (2005). Columbia Journal of Gender and Law, Vol. 2, 2005, Emory Public Law Research Paper Forthcoming, Available at SSRN: https://ssrn.com/abstract=2103393

12 Dissemination/Publication

12.1 The Panel shall, once it has agreed the final report, submit it to the Kent Community Safety Partnership and the KMSAB for its consideration. The Partnership's will be requested to consider the content of the report, the recommendations, and the associated Action Plan. If the Partnerships are satisfied with the report, it shall be requested to submit the report to the Home Office.

12.2 The overview report will be published on the website of Kent and Medway Community Safety Partnerships and also on the KMSAB website.

12.3 Family members will be provided with the website addresses and also offered hard copies of the report.

12.4 Further dissemination will include:

(a) The Kent and Medway DHR Steering Group, the membership of which includes Kent Police, Kent and Medway Integrated Care Board and the Office of the Kent Police and Crime Commissioner amongst others,
(b) The Kent and Medway Safeguarding Adults Board,
(c) The Kent Safeguarding Children Multi-Agency Partnership,
(d) Additional agencies and professionals identified who would benefit from having the learning shared with them.

12.5 In accordance with Home Office guidance all agencies and the family and friends of Angela are aware that the final overview report will be published. IMR reports will not be made publicly available. Although key issues, if identified, will be shared with specific organisations, the overview report will not be disseminated until clearance has been received from the Home Office Quality Assurance Panel.

12.6 The content of the overview report has been suitably anonymised to protect the identity of the female who died and relevant family members and friends. The overview report has been produced in a format that is suitable for publication with any suggested redactions before publication.

13 Background Information (The Facts)

13.1 Angela was the mother of one child who lives with the biological father. Angela was in her 30s at the time of her death. She had spent most of her adult life in Spain, where she moved after the death of her mother. Angela started a relationship with her ex-partner Joseph in November 2019 where shortly afterwards she fell pregnant. Her baby was born 16 weeks premature. There were a number of health complications with the baby which meant that they spent a considerable amount of time in different hospitals. During the time in hospital Angela would visit and spend time most days with her baby.

13.2 Angela was alcohol dependent and sadly her alcohol problems did not cease during or after her pregnancy. When discharged from hospital Angela and the baby both went to live with Joseph and his family. A Child Protection Plan was put in place in March 2021 by Social Services due to concerns surrounding Angela's ability to care for the baby. Joseph was working nights at this point and concerns were raised regarding Angela abusing alcohol and the impact that this had on the care she was providing. Due to the concerns, Angela left the family address and contact was minimised to four hours supervised a day. The baby was left in the care of Joseph and his family. The loss of her baby had a significant impact on Angela's drink problems and subsequently her mental health.

13.3 Shortly after leaving the family home Angela made an attempt on her life by taking an overdose of tablets and alcohol. She received hospital treatment before being discharged under the care of the crisis team. Angela went to stay with her sister however, this was always identified as a short-term solution due to the lack of room. Although identified as short-term Angela stayed with her sister for several months before becoming homeless. Due to Angela's alcohol abuse and mental health problems, she was placed in temporary accommodation in a hostel.

13.4 Whilst living in the hostel Angela started a relationship with a male, Anthony. This relationship appeared to take place over a two-week period and during that time Angela made a report to the police that she had been raped by Anthony whilst at the hostel. Anthony was arrested for the offence of rape and bailed to live at different accommodation.

13.5 In 2021 Angela was found unconscious in her room. She was taken to hospital where she later sadly died. Joseph and the baby were due to visit the hostel to see Angela at the same time as she was found. Joseph stated that he had had text conversations about seeing her minutes before she was found by staff members. Joseph stated that the text messages were upbeat and stating that she was looking forward to spending time with Joseph and their baby.

14 Chronology

14.1 In September 2019, Angela was registered at GP practice 1 using her sister's address. Angela's first contact with the practice was in May 2020 at the pregnancy booking appointment with a midwife. Angela mentioned to the midwife a history of Bulimia[7]. She was offered counselling with the practice counsellor which she took up.

14.2 On the 7th May 2020 Angela attended her eight week antenatal appointment. Angela was looked after by the Community Midwife who completed a risk assessment with her. She was identified as a 'low risk' pregnancy. Angela's history in relation to mental health, alcohol and drugs misuse were noted during the risk assessment and she was also asked about her relationship and she stated there was not any domestic abuse.

14.3 On the 9th May Angela was brought into the emergency department Maidstone and Tunbridge Wells NHS Trust It was identified that she had an ovarian cyst. Angela remained in hospital for two days before being discharged.

[7] Bulimia is **a psychological eating disorder in which you have episodes of binge eating** (consuming a large quantity of food in one sitting). During these binges, you have no sense of control over your eating. Afterward, you try inappropriate ways to lose weight such as: Vomiting. Fasting.

14.4 On the 16th July Kent Community Health NHS Foundation Trust (KCHFT) received a Concern and Vulnerability Notification form[8]from Maidstone and Tunbridge Wells Acute NHS Trust for Angela regarding relevant health concerns including being diagnosed with Stevens-Johnson Syndrome[9], Bulimia Nervosa, previous substance misuse and information about family and environmental factors including overcrowding and Angela's partner suffering from ill health and his father being diagnosed as terminally ill. A HV was allocated to the family.

14.5 Angela was first referred to the Kent and Medway NHS and Social Care Partnership Trust (KMPT) in July by her Midwife. The referral informed that Angela had a diagnosis of Bulimia Nervosa, she was pregnant and that the pregnancy was problematic. Angela was also said to have a history of substance misuse including cocaine and cannabis.

14.6 On the 15th August Angela was seen in the antenatal triage at 22 weeks and 5 days' pregnancy where it was found that she had had a spontaneous rupture of her membranes. She was transferred to Brighton and Sussex University Hospitals NHS Trust for the pre-term delivery of her baby.

14.7 After the birth, the baby had to stay in the neonatal intensive care unit initially. During the baby's stay at the hospital a call was received by staff stating that Angela used excessive alcohol, was a historic substance misuser and was suffering from mental ill health. There is no record of who made the call.

14.8 Angela reported having low moods and anxiety during a post-natal review with the midwife and was referred to the GP. Angela also reported separation anxiety but denied any drug or alcohol use. She was started on antidepressants and continued to see the counsellor.

[8] These notifications are standard practice where relevant health concerns are identified by Midwife therefore other health agencies such as GP and health visiting would be informed as part of information sharing processes.

[9] Stevens-Johnson syndrome (SJS) is a rare, serious disorder of the skin and mucous membranes.

14.9 On the 26th August the KCHFT HV service received a call from the hospital informing them of the birth of Angela and Joseph's baby. Several conversations took place between the HV and other Health professionals regarding Angela and her baby, and the support being offered. The HV had tried to contact Angela on numerous occasions but had not been able to make contact. Concerns were expressed regarding Angela's mental health and previous issues surrounding alcohol dependency. It was identified to the HV that Angela had been referred to the Mother and Infant Mental Health Service (MIMHS). The referral was declined by MIMHS as Angela did not fit the criteria at that time. Angela was however referred to Early Help as she was struggling with home life. It was also reported that Angela was under the mental health midwife at Medway who was supporting her.

14.10 On the 11th September Medway hospital neonatal unit nurse obtained the Midwifery "Concerns and Vulnerability Notification form" from the hospital safeguarding team. A request for support was submitted to Integrated Children's Services (ICS) by a midwife following the premature birth of Angela and Joseph's baby who was in neonatal care.

14.11 On the 12th September Angela visited the baby in the Medway Special Care Baby Unit, she appeared very tearful, and said that she was feeling anxious and was not sleeping. Angela recognised that she may be suffering from post-natal depression and that she was going to speak to her partner about it. She also expressed concerns that she was going to be referred to social services.

14.12 Angela, Joseph and the baby were discussed at the hospital's Multi-Disciplinary Team (MDT) meeting, and it was identified that the Lead Specialist Mental Health Midwife would discuss with Angela what support could be offered and to also make a referral into social services for further support.

14.13 On the visit to the hospital by Angela on the 12th October, concerns were raised by hospital staff that she may be intoxicated due to her behaviour. An email was sent to the Children's Safeguarding Team to update them regarding concerns that Angela has been drinking. An MDT meeting was also held to discuss the concerns surrounding Angela.

14.14 On the 16th October, Angela and Joseph were spoken to by the Early Help Worker at their home address. It is recorded that both Angela and Joseph visited their baby on a near daily basis although it was identified that the baby was very poorly a great deal of the time which would have significantly raised the pressure for both parents. Angela agreed to a referral to Early Help and requested a housing support letter.

14.15 Angela and Joseph approached the District Council in October and applied to join the housing register with their baby. Following assessment, it was identified that their current accommodation (Joseph's family home) was overcrowded so they were placed in Band B[10] on the priority list.

14.16 On the 21st October the HV made contact with Angela to discuss the support available for her. The baby was in hospital at this point, having been transferred on the 13th October and it was identified that Angela and Joseph were struggling financially as they were having to pay fares to visit the baby on a daily basis which was using up all their money.

14.17 On the 26th October the HV visited Angela at her home address however Angela was not there but was at the hospital visiting the baby.

14.18 On 18th November Angela's case stepped up to additional support within ICS. This was due to further concerns raised by Medway hospital around Angela's drinking. Angela was informed of the decision and stated that she was fine with it.

14.19 A Strategy Discussion took place on the 20th November led by ICS. A single agency Section 47[11] was agreed and the outcome was to progress to an Initial Child Protection Conference (ICPC) due to concerns around housing, risk of Sudden Infant Death Syndrome, Angela falling asleep at the hospital and her alcohol use.

[10] Every application is placed into a band including all home seekers and transfers, which helps to identify who most needs housing. The band that you will be placed in will be decided by a number of factors listed in each local authority lettings policy. Applicants with the greatest housing need will be placed into Band A. Applicants with a lower housing need will be placed in a lower band.

[11] Section 47 Enquiries start when: There is reasonable cause to suspect that a child who lives in or is found in, a local authority area is suffering or likely to suffer significant harm in the form of physical, sexual, emotional abuse or neglect

14.20 On the 26th November the HV received a call from Early Help regarding Angela. The HV was advised that a Strategy Meeting had taken place, unfortunately the HV had not been invited. It was identified by the Social Worker (SW) that Angela was continuing to drink alcohol excessively and as such it had been decided that under Section 47 the plan was stepped up from early help to a Child Protection Plan. Although the HV wasn't invited a representative from the hospitals safeguarding team and a health representative from the Front Door Service (Central Referral Unit) were invited and attended so were able to share information about Angela and her baby.

14.21 An ICPC took place on the 17th December where it was agreed that the threshold for making the baby a subject of a Child Protection Plan was not met due to the family being a protective factor. The Chair recorded that they felt that the case had progressed too quickly to ICPC and the family needed an opportunity to demonstrate they were a protective factor. It was also noted that Angela and Joseph were both working with professionals and taking on board their advice. A Child in Need plan (CiN) was established which outlined hair strand and blood PEth[12] testing for Angela as they had not been completed prior to the ICPC as planned. Angela was admitted into hospital with abdominal pains, and it was noted that her liver test results were abnormal.

14.22 Hair and blood tests were sought by ICS and when received the results raised grave concerns around the level of sustained and excessive alcohol use indicated and the honesty of the paternal family. A subsequent strategy meeting took place which decided that the paternal family were a protective factor although it has been identified that no specific analysis had actually taken place regarding their ability to protect. There is no suggestion in this case that the appropriate support was not offered to Angela by Joseph or his family, what has been highlighted within the review is the lack of consideration given by agencies in relation to the family dynamics and the impact on Angela.

14.23 A CiN meeting was held on the 13th January 2021 which was attended by Angela and Joseph.

[12] A PEth blood test measures the level of phosphatidylethanol, a direct alcohol biomarker which is found in human blood following alcohol consumption.

14.24 On the 25th January a discharge planning meeting was held for the baby. It was discussed at the meeting that Angela's hair strand test indicated long term alcohol misuse although no discussion took place regarding Angela's' current usage of alcohol. Support was to be offered to Angela regarding alcohol misuse and an Early Help Worker would work with the family to help manage the baby's care two days a week. The baby was discharged home on the 28th January.

14.25 On the 2nd February a KCHFT Care Coordinator within the Children Therapies Team carried out a home visit with the speech and language therapist. This was at Joseph's home address with the baby. A couple of days later a referral was made to Portage[13]. A previous referral had already been made and accepted by Maidstone and Tunbridge Wells NHS Trust. Several contacts took place between the HV and the family, and support provided.

14.26 A CiN meeting took place on the 12th February. Angela was asked if she had drunk any alcohol since the last meeting and she reported that she had not.

14.27 On the 24th February a Strategy Meeting took place where Angela's blood and hair strand tests were discussed. The SW worker reported that the test was 'chronic', and it was felt by the professionals that Angela was not telling the truth around her alcohol problem. It was also reported during the strategy meeting that the SW had spoken to Joseph's mother, the paternal grandmother, and she had reported that they were all worried about Angela and her drinking – she had been drinking excessively whilst pregnant reporting that she had come home at one time after having an eight hour drinking session and there had been lots of arguing in the house. It was identified that Angela had an appointment with Change Grow Live (CGL)[14] and that she was working well with them although it is unknown where this information came from and that this was not followed up. (During the review CGL have identified

[13] Portage assists parents to complete applications for Disability Living Allowance and Carer's allowance. It is also an Educational Service for pre-school children with Special Educational Needs and Disabilities, offering bespoke packages of intervention to support a child's development through Pre-school learning groups and or home learning sessions.

[14] Change Grow Live is a voluntary sector organisation specialising in substance misuse and criminal justice intervention projects in England and Wales.

that they did not work with Angela during this time.) The suggestion at the meeting was for the baby's cot to be put into the grandmother room at night as Joseph was working nights and there were concerns regarding Angela's ability to look after the baby during the night if under the influence of alcohol. A decision was made that the baby would stay as a Child in Need. Home visits took place by the HV where no concerns were raised.

14.28 A further concern was raised to ICS on the 3rd March surrounding Angela and her ability to care for her baby. An emergency strategy discussion took place. It was identified that the baby appeared unkempt and was without their nasal tube for some time and Angela was observed as being erratic and dismissive. It was also identified that Angela was not being supervised by Joseph or the parental family which led to concerns regarding possible collusion or inaction. The baby's grandmother informed the social worker that she had found a bottle of vodka in Angela's bedroom. The concerns that family members had were identified as not being shared with Children Services. The decision was made that an emergency visit would take place at the home address to check the welfare of the baby and that Angela would be supervised at night. An Initial Child Protection Conference would be arranged within 15 days.

14.29 A home visit took place by the SW. It is reported that Angela continued to deny abusing alcohol and stated that she was cutting down. Angela reported that she had been acting strange the day before not due to alcohol but due to her mental health problems. Concerns were expressed in relation to possible suicide by the SW regarding Angela and the impact on her if she was asked to leave the baby and the family home. During the home visit a conversation took place between the SW, Angela, and family members where the family were asked to identify a 'Family Safety Plan', to identify how they as a family would keep the baby safe within the family home.

14.30 The HV carried out a home visit on the 4th March where the baby appeared well. Angela appeared upset and identified to the HV that she had been advised by the SW that she had to move out of the family home due to the incident at the hospital and the recent meeting held with professionals. Angela was very upset and stated that she had nowhere to go. Details of agencies who could offer support regarding accommodation were given to

Angela. The HV contacted Porchlight and CGL. A referral was made into Adult Social Care in relation to Angela but the referral was highlighting the housing difficulties that Angela was facing and was not a safeguarding referral or a referral for an assessment of Angela's care and support needs.

14.31 On the 8th March the KCHFT Speech and Language Therapist had contact with Angela, Joseph and the baby. Angela was reported as being very tearful about being asked to move out of the home. Angela's mental health was not considered during this visit and no additional support was offered to her. A short while later Angela moved out of the family home leaving the baby in the care of Joseph and his family.

14.32 On the 9th March Angela was found under the influence of alcohol and in possession of vodka on a contact day with her baby.

14.33 On the 9th March the Adult Risk Management Worker contacted the KMPT Single Point of Access (SPoA) regarding Angela as she had been found presenting as distressed at a train station. SPoA advised that police assistance would be required first due to the reported risk before taking any referral information.

14.34 On the 10th March the HV received a phone call from Angela's sister expressing concerns about Angela. Angela had been found at the railway station the previous night, very intoxicated. She had been taken to the hospital where she waited all night before telling hospital staff that she had taken an overdose of Joseph's medication. Angela was admitted to hospital where she was assessed by KMPT. Angela had informed hospital staff that she had nowhere to live. The Mental Health team did not feel that Angela needed to be admitted to a unit. Angela was discharged from hospital into the care of her sister who had agreed that she could stay with her for a couple of nights as she was homeless. Angela was referred to the KMPT Mental Health Liaison Psychiatry Liaison Service (LPS). During the assessment Angela stated that she had left the family home after being given the option of vacating the home or her baby being placed into care by social services. She stated that she was continuing to engage with alcohol misuse services (CGL), and she additionally stated that she was experiencing suicidal thoughts but with no plan or intent to act on these. The clinician spoke to both Joseph and Angela's sister. Angela

was discharged from LPS and referred to the Crisis Resolution Home Treatment Team (CRHT). Angela was seen by the CRHT on six occasions at her sister's home address. She was then transferred to the Community Mental Health Team (CMHT) on the 22nd March.

14.35 On the 11th March the HV made a follow up call to Angela's sister who stated that Angela was reserved and was not speaking very much after being released from hospital. Angela's sister stated that Angela could only stay with her for a couple of weeks as she did not have a lot of room and her children were now having to share a room so that Angela could have a room. The Duty HV later spoke to Angela who was very tearful stating that she was okay at present and was not going to do anything with regards to putting herself in harm. Angela disclosed that she had a drinking problem and that after leaving the family home and her baby she had hit rock bottom. Angela stated that the Mental Health Crisis Team were coming to see her. The HV directed Angela to appropriate support services.

14.36 On the 16th March the HV contacted Angela. Angela informed her that her relationship with Joseph had broken down and that they were currently not together and had decided to take some time apart. Angela also stated that Joseph's family have been very hostile towards her and she was finding this difficult when she visited the baby. Angela mentioned that she had not heard anything from her counsellor or CGL. There does not appear to have been any further discussion regarding Joseph or his family and there are no reports regarding any domestic abuse.

14.37 On the 17th March a multi-agency meeting was held which took place prior to the second ICPC. It was reported at the meeting by the HV that she was worried about Angela and her current situation with housing and her mental health and that she was currently vulnerable. A full housing assessment also took place with Angela where a referral was made for supported housing. The KCHFT Care coordinator met with Joseph, Angela and their baby to coordinate the Children's therapy teams contacts with the family. KCHFT were involved with the family as the baby had additional needs which needed additional support from therapy services. ICPC conference reports were shared with Angela and Joseph.

14.38 On the 22nd March a second ICPC was held regarding the baby and concerns of neglect. A decision was made that the baby would be subject of a Child Protection Plan under the category of neglect. There is no evidence of Angela's GP being informed of this meeting or the outcome, which is a gap, especially as Angela discussed her medication as a part of the meeting.

14.39 The CMHT completed a follow up call to Angela on the 23rd March who reported that she was having daily contact with her baby and that she was working on her housing issues. Angela denied suicidal thoughts throughout the call.

14.40 On the 24th March a referral was made into the Adult Referral Management System (ARMS), the front door into Adult Social Care (ASC) by the HV for Angela stating, '*Homeless as told to leave ex partners house where child and paternal grandmother lived otherwise child would be removed*'. The referral was assigned to the Mental Health (MH) Screening South-West Team.

14.41 The Borough Council A received a homeless application from Angela in March saying that she had been asked to leave the home where she was living with Joseph, his family, and their baby, by social services due to her drinking and not being able to care for her child. A vulnerability assessment was undertaken however Borough Council A at this time had no reason to believe that Angela had a priority need for housing. However, at the time of the approach the Severe Weather Emergency Protocol (SWEP)[15] was active so Angela was offered short term accommodation.

14.42 On the 26th March the HV made a call to Angela who stated that she was not visiting the baby as Joseph was taking them to visit his other children.

14.43 Porchlight received a referral in March regarding Angela from KCHFT as Angela was due to be made homeless due to concerns from social services around substance misuse issues (alcohol) and being able to look after her baby.

[15] Severe Weather Emergency Protocol (SWEP) describes spaces opened as shelter for people sleeping rough when there is an increased risk of death due to the weather e.g. temperatures fall near or below freezing.

14.44 A telephone screening took place with Angela and the MH SW on the 31st March. The KCHFT allocated HV visited Angela at her sister's home address.

14.45 On the 7th April Angela made an online self-referral to We Are With You[16]. She was contacted by text and a telephone assessment was booked. Angela then completed a person to practitioner assessment where she indicated symptoms of moderately severe depression, moderate anxiety and mild psychological distress. Angela was offered treatment but did not attend any of the follow up sessions.

14.46 On the 8th April KCHFT HV received a phone call from Angela stating that she had not heard anything from housing or Look Ahead. She did state that she had spoken to her SW. The HV made follow up calls to the SW and Porchlight. The HV was reminded to complete the referral for Initial Intervention for Angela as well as recommending that Angela was placed on the team's Active Review Team (ART) waiting list, however, this did not take place until the 15th April. It is not understood what caused the delay in placing Angela on the list which would have initiated contact by KMPT. The contact by the ART which was due to take place on the 21st April also did not take place.

14.47 On the 12th April a referral was made by Mental Health to the Kent Enablement and Recovery Service (KERS). KERS works in partnership with individuals experiencing mental health difficulties to address social care needs. Unfortunately, the letter was sent to the wrong address and as Angela did not attend her appointment on the 23rd April it was recorded as 'Did Not Attend' (DNA). A second appointment letter was also sent to the wrong address which again resulted in a second DNA. No attempt was made to contact Angela by phone.

[16] We Are With You is an Improving Access to Psychological Therapies service offering brief psychological therapies to people with mild, moderate or severe anxiety and/or depression.

14.48 On the 14th April the KCHFT HV visited to weigh the baby. Joseph and Angela were present. It was noted that Angela appeared upset and told the HV that she was worried as she needed to leave her sister's home and really needs a place of her own. Angela also stated that she had spoken to the mental health team who were recommending that she admits herself to a London hospital for one month to help with her addiction and her mental health. There are no records of this in any other agencies' reports.

14.49 A Core Group was held on the 15th April. A discussion took place about Angela doing everything she was being asked to do by the professionals although she was struggling with the number of appointments and contacts by professionals. Angela's housing situation was also discussed and the fact that Angela was under pressure to leave her sister's house due to there not being enough room for her. There is no evidence that consideration was given for Angela and the baby going to a mother and baby unit. Contact took place between the HV and Look Ahead regarding accommodation for Angela.

14.50 On the 21st April the HV received a phone call from Angela's brother-in-law reporting that the housing situation was becoming stressful and overcrowded and that Angela was now sleeping on the floor. It is unclear as to why the family are also now contacting the HV regarding Angela's housing situation. The housing situation appears to deteriorate over the next few days and further calls were received by the HV.

14.51 On the 30th April the HV received a call from Angela reporting that she had been discharged from hospital following keyhole surgery for a burst ovarian cyst and that she was only able to stay at her sister's for a couple more days. The HV contacted the GP in relation to medication for Angela.

14.52 On the 4th May the HV made a second referral into the KERS at KCC expressing concerns regarding Angela, stating that she was living with her sister and brother in law but was about to be made homeless.

14.53 On the 5th May Angela submitted a further homeless application form, advising that she was temporarily staying with her sister but that her sister had asked her to leave. The Council received information that Angela was sleeping rough but upon contact on the 6th May Angela stated that she was again staying with her sister. This was because Angela's sister had agreed that the hospital could release Angela into her care.

14.54 A self-referral was received into the housing department from Angela on 5th May stating that she was sleeping on her sister's floor and then became street homeless. Angela was helped to complete the application form by the HV and was supported by the housing charity before moving into hostel A.

14.55 A Family Group Conference was held on the 10th May.

14.56 A Review Child Protection Conference (RCPC) took place on the 11th May. Angela's mental health and housing were discussed but it was acknowledged that Angela had done everything she could to get the support she needed but kept 'Hitting brick walls'.

14.57 On the 14th May Angela was verified as sleeping rough by the Porchlight Outreach Worker. Angela was referred to a housing project for an assessment as a vulnerable adult with mental health issues. Angela moved into hostel A.

14.58 Angela identified to a Core group meeting for the baby on the 17th May that hostel A where she was living was 'very rough'. Angela reported that she continued to take her medications, was feeling tired but not suicidal and realises that she needed to take them to keep her feeling that way.

14.59 On the 18th May the Council had contact from Joseph advising them that he wished to be removed from the joint housing register application, along with the baby, as he wished to begin a fresh application in his and the baby's name only.

14.60 On 19th May the HV undertook at home visit to Joseph's house to weigh the baby. Angela and Joseph were both present. Angela appeared well.

14.61 Later in May the SW from Adult Social Care contacts Angela where she identified that she was in a Hostel but was receiving support to find her permanent accommodation. Angela reported that she was '*Physically and mentally better and focusing on maintaining a relationship with her ex-partner and was having daily contact with her baby'.* Angela indicated to the SW that she wanted KERS to support her. Contact was also received from Angela's GP sharing appropriate information concerning Angela. Angela appeared to be allocated for an assessment however, this did not take place before her death.

14.62 In May Angela moved into the supported hostel, Hostel B, she had been fast tracked into the hostel due to her physical health. Shortly after moving into Hostel B it is documented that she started a relationship with Anthony. Anthony had moved into the hostel in September 2019.

14.63 In June Angela collapsed at the hostel and was rushed to hospital due to a burst ovarian cyst. Angela needed an operation and was discharged back to Hostel B six days later**.**

14.64 A member of staff at the hostel where Angela was living contacted the police to report the fact that Angela was making an allegation of rape and coercive and controlling behaviour against another hostel resident, Anthony. Anthony was arrested at the hostel and upon release was given bail conditions not to return to the hostel or to contact Angela. A Domestic Abuse Risk Assessment (DARA) was undertaken which was graded as high and a safeguarding referral was made. A referral was made into the Independent Sexual Violence Adviser service (ISVA).

14.65 A Kent Adult Safeguarding Alert Form (KASAF1)[17] was received following disclosures by Angela of sexual and physical assault in the hostel that she was living in. (A new online safeguarding referral form has been developed by KCC which is now being used by agencies).

[17] A KASAF1 is an online safeguarding concern form.

14.66 Angela was seen by the in-house therapist at Hostel B. She was asked explicitly about suicide ideation, and she said she had no plans to take her own life and that her baby was the strongest reason for this. The support worker from Hostel B contacted the HV to report that Angela was back at the hostel and was asleep on the sofa in the lounge area. The HV advised the hostel support worker that due to Angela's vulnerabilities she needed a safe place to stay. The HV spoke to Angela later at the hostel due to concerns over an argument that had taken place between Joseph and Angela. The argument appeared to be about the relationship between Angela and Anthony. Angela reported to the HV that she wanted to leave the hostel and go to a refuge. The HV received a call the next day advising that a refuge place was available in Essex or Hertfordshire, but Angela declined as these were too far away for her to travel to see her baby.

14.67 In June staff at Hostel B reported to the police that Anthony had breached his bail conditions and had been posting on the hostel group chat that Angela was a liar and that she was making the allegations up. This caused Joseph to consider taking away Angela's visitation rights with her baby which caused Angela a lot of stress. It was also identified that Joseph had sent text messages to Angela after finding out about her relationship with Anthony which were of an unpleasant nature. Joseph stated that he sent these messages in anger and regretted it and that himself and Angela had spoken after the messages and had agreed to work together on their relationship. Joseph had also had a conversation with the HV about receiving messages from Anthony regarding the relationship he was having with Angela and that these had upset him considerably.

14.68 Angela was found unconscious. She was taken to hospital and placed on life support. Joseph and the baby were on their way to visit Angela at the hostel and arrived following the ambulances. Joseph identified to the Chair that he had been having text messages with Angela who was looking forward to the visit up to 10 minutes before he arrived.

14.69 In June the police submitted a Multi-Agency Risk Assessment Conference referral. This has been identified by the police as being too late and has been discussed within the learnings.

14.70 A Core Group meeting took place. It was acknowledged at the meeting how sad the situation was and if Joseph needed further support it was available to him.

14.71 Angela sadly passed away.

15 Agency Analysis

15.1 **Kent & Medway Clinical Commissioning Group (Primary Care)** (Integrated Care Board - ICB)

15.1.1 Angela registered with practice 1 in September 2019 using her sister's address however, her first contact with the surgery was in May 2020 at the pregnancy booking appointment with the midwife. Angela's history of Bulimia and Stevens-Johnson Syndrome was noted in her GP records, together with a history of substance misuse. Her mood was recorded as being low and she was suffering anxiety relating to the overcrowding at her partner's address. Angela was offered counselling at the GP surgery which she accepted.

15.1.2 Following the birth of Angela's baby in August 2020 and the baby needing to stay in the neonatal intensive care unit Angela reported low mood and anxiety at her post-natal review with the midwife. This was immediately reviewed by the GP. Angela reported having anxiety due to being separated from her baby but denied any drug or alcohol abuse. The GP started Angela on antidepressants and Angela stated that she was still seeing the counsellor. Angela was monitored by the GP over the next few months and her anxieties were noted as being related to COVID-19 and travelling to the hospital to see her baby.

15.1.3 In December 2020 the GP wrote a detailed letter for Children's Services noting the fact that Angela was living with her partner although her address at the practice was still her sister's address. The letter clarified that Joseph and the baby were not registered at the same practice. This letter would have been for the first ICPC meeting which took place regarding placing the baby on the child protection register. There are

good examples of agencies being invited to attend or to contribute to ICPC meetings however, this is not consistent throughout the review. The decision was made at this meeting that the criteria for registration had not been met.

15.1.4 In March 2021 Angela was seen by the Liaison Psychiatry Team following an attempted overdose apparently triggered by being asked to leave the family home due to her alcohol dependency. Angela tried to obtain medication from Practice 2 which is the catchment area for where Joseph and his family lived but due to difficulties obtaining the medication, she re-registers with Practice 1. The HV contacted the GP from Practice 1, and it was agreed that Angela could remain registered at Practice 1 until she had permanent housing in view of her vulnerabilities. This is an example of good supportive work by the GP and the HV.

15.1.5 Angela had regular contact with the GP from Practice 1 over the following weeks relaying anxieties related to her housing situation and the limited contact with her baby. Angela continued to engage with counselling and had antidepressant medication prescribed. The GP provided Children Services with a further update in May 2021.

15.2 Medway NHS Foundation Trust

15.2.1 Medway NHS Foundation Trust is a single-site hospital. Angela was brought into the emergency department in February 2020 with a suspected ectopic pregnancy but following investigation it was identified that Angela was 7 weeks pregnant. Angela was known to the Specialist Mental Health Midwife to have a documented past history of drug use and alcohol use. Angela told the midwife that she used to live with her previous partner in Spain but that he had died suddenly; following this Angela had had a breakdown and had returned to the UK to live. Angela

disclosed that she had been drinking in pregnancy and more so towards the end of her pregnancy. It was not recorded as to whether Angela was accessing any support surrounding her alcohol usage and there was a missed opportunity for Angela to have been signposted to alcohol misuse services.

15.2.2 Angela's mental health was observed to be very fragile, and she was often observed to be anxious, upset and tearful. Angela acknowledged that she might be suffering from post-natal depression. The Community Midwife referred Angela to the Maternal and Infant Mental Health Services (MIMHS) however, the referral was declined. It was acknowledged that Angela was having weekly counselling at her GP surgery.

15.2.3 Angela and Joseph visited their baby in the Neonatal Unit nearly every day. No concerns were raised regarding the relationship between them as a couple. Angela reported that Joseph was supportive towards her although he did not understand post-natal depression and how it was affecting her. On occasions Angela was observed as falling asleep at the baby's cot. Angela was offered hospital accommodation two weeks after the baby's admission to the Neonatal Unit. The baby was transferred to another unit in October 2020.

15.2.4 Angela further attended the hospital in March 2021 feeling suicidal and had taken an overdose of Tramadol[18]. Angela reported to staff that she had never done anything like this previously and it was noted that her sister was recorded as her next of kin. Angela was seen by the Liaison Psychiatry team. She informed the team that she was homeless having left her home two days previously as a result of being asked by social services to leave due to her alcohol misuse. Angela was discharged into the care of her sister and her GP was written to and a referral was also made to the Crisis team for home treatment and support. It is recorded

[18] Tramadol is an opioid pain medication used to treat moderate to moderately severe pain.

that Angela was continuing to access support from CGL, however this was not clarified and it has been identified during the panel meetings that although receiving two referrals from professionals, CGL were not working with Angela as she had identified.

15.3 **Borough Council A, Housing**

15.3.1 Angela initially approached the Council and applied to join the housing register in October 2020 together with her partner Joseph and their baby. Information was received from Kent County Council supporting a move for the family due to the baby's prematurity and the fact that the house he would be discharged from hospital to was overcrowded. The application was triaged to see if there were any safeguarding issues identified, but nothing was identified at this point.

15.3.2 In March 2021 the housing department received an approach from Angela stating that she would be homeless that day as she had been asked to leave the family home due to her drinking and not being able to care for her baby. Contact was made with Social Services and a vulnerability assessment was undertaken with Angela. Angela disclosed that her baby would not be moving with her and that she had an issue with alcohol and was engaging with CGL. Angela also stated that she had experienced post-natal depression and was awaiting a referral to the Community Mental Health Team. At this time the housing department had no reason to believe that Angela had a priority need for housing and so she was advised that she would not be provided with interim accommodation. However, at the time of the approach the Council's Severe Weather Emergency Protocol (SWEP) was active so Angela was offered short term accommodation.[19]

[19] Severe Weather Emergency Protocol (SWEP) describes spaces opened as shelter for people sleeping rough when there is an increased risk of death due to the weather e.g. temperatures fall near or below freezing.

15.3.3 The Borough Council Housing department were contacted by KCC Integrated Children Service's advising that Angela was in hospital having attempted suicide and that she was homeless still, but that on discharge she would be staying with her sister short term. Angela was contacted and her application reviewed. It was again established that she did not have a priority need. A referral was made to Porchlight and also for supported housing. Contact was made with ICS and copies of the ICPC report, speech and language therapists report, the Maidstone hospital named nurse safeguarding report and the clinical lead specialist nurses report were all shared with the Borough Council Housing. ICS also confirmed that Angela was likely to have the baby in her care again and that the baby should be considered as part of her housing application. This is an example of good information sharing between agencies.

15.3.4 In May 2021 Angela submitted a further homelessness application form, advising that her sister had asked her to leave and that she had nowhere to go. The Council accepted the duty relief and also received reports that Angela was sleeping rough. However, the next day Angela contacted the Council and stated that she was staying with her sister. Subsequently, Angela was verified as rough sleeping by the outreach service on the 14th May 2021 and as such she was placed in accommodation. Angela was discussed at the Rough Sleeper task force where it was identified that she had moved into Hostel B.

15.4 **Kent County Council, Adult Social Care**

15.4.1 In March 2021, a referral was received into Adult Social Care (ASC) by a HV looking after Angela and Joseph's baby. The referral stated that Angela had become homeless after being told to leave her ex-partner's address where her baby and paternal grandmother live, otherwise her baby would be removed. The Out of Hours team (OOH) were contacted and advised that the police might be in contact as Angela had been found distressed at a train station. No contact was made by the police. Angela was offered a duty screening appointment and following this a referral was made to the Kent Enablement and Recovery Service (KERS). This service works in partnership with individuals experiencing

mental health difficulties to address social care needs. During the next month two appointment letters were sent to Angela however, it was later identified that these letters were sent to the wrong address and were therefore not received. No follow up calls were made and as such Angela's referral was closed due to 'non-attendance'.

15.4.2 In May 2021 ASC were again contacted by the HV expressing concerns regarding Angela. It was identified that Angela was living with her sister but had been asked to leave and was now homeless. The HV had contacted several agencies in an attempt to get someone to support Angela and had contacted Porchlight (a charity that is able to help with homelessness), the Crisis team and Single Point of Access team within KMPT. The HV was given the number for the Mental Health Social Worker. Several attempts were made to contact Angela by phone throughout May but no contact was made. A meeting took place between a SW and Senior SW where it was planned for the duty worker to contact the community mental health team (KMPT) to investigate reasons for non-engagement and a request made to feedback to the senior SW. It was only at this point that the SW identified through accessing Angela's health records that she had taken an intentional overdose of tablets in March 2021. This information had not been made available to ASC previously and might have changed the way that they interacted with Angela.

15.4.3 Good work was identified by the SW who tried to contact different agencies to establish Angela's whereabouts and to try and get her to make contact with them. Contact was also made with Children's Services Front Door asking them to confirm their involvement and also advising that Angela had not been seen by the MH Social Care following her overdose. A further letter was sent to Angela inviting her to undertake an initial assessment. On the 21st May 2021 the SW successfully contacted Angela. Angela informed the SW that 'she was physically and mentally better and was focusing on maintaining her

relationship with her ex-partner and was having daily contact with her baby'. Angela's housing situation was also discussed. Angela stated that she would like KERS to support her. Angela was informed that if she felt that she needed further support, to contact her GP who can refer her for a social care assessment.

15.4.4 On the 10th June 2021, a Kent Adult Safeguarding Alert Form (KASAF1) was received by ASC following the disclosure by Angela of a physical and sexual assault on her whilst living at Hostel B.

15.5 Maidstone and Tunbridge Wells NHS Trust

15.5.1 Angela was known to Maidstone and Tunbridge Wells NHS Trust (MTW) in relation to her pregnancy and birth of her baby. She was assessed as being medically 'low-risk' but her history in relation to mental health, alcohol and drug misuse was noted. Angela also stated that there were not any incidents of domestic abuse within her relationship. The staff from MTW were actively engaged with the multi-agency Child Protection Plan and Child in Need meetings that were held by ICS.

15.5.2 Following Angela's admittance to hospital in December 2020 with abdominal pains it was noted that her liver test results were abnormal. The Named Nurse for Safeguarding Children was informed, and staff were advised to signpost Angela to CGL. Due to Angela's sometimes erratic behaviour and falling into unarousable sleep when visiting her baby, suspicions were raised that Angela had been drinking alcohol excessively. Angela always denied this when asked. A multi-agency case conference took place which focused on Angela's suggested alcohol intake and her housing situation. Angela was admitted to Maidstone and Tunbridge Wells hospital on two occasions regarding abdominal pains which were diagnosed as ovarian cysts. The last time being when she was resident at Hostel B.

15.5.3 MTW had several dealings with Anthony due to his diagnosis of Type 1 diabetes and his poor compliance with his treatment. Anthony had also presented to the ED on five occasions with either overdose or suicide ideation. On three of these occasions, he was referred to Liaison Psychiatry Services run by KMPT. On two of these occasions he did not wait to see this service.

15.6 Kent & Medway NHS and Social Care Partnership Trust (KMPT)

15.6.1 Angela was initially referred to the KMPT Mother and Infant Mental Health Services (MIMHS) by her midwife in July 2020 for mental health support. The midwife highlighted that Angela had a diagnosis of Bulimia Nervosa and was experiencing a problematic pregnancy. The Midwife reported that Angela had social stressors that included a difficult living situation as well as reporting a history of substance misuse of cocaine and cannabis. The referral was deemed not to be appropriate by the MIMHS as Angela did not have any “perinatal specific mental health needs”.

15.6.2 Angela also had contact with the Single Point of Access, Community Mental Health Team (CMHT) and the Crisis Resolution and Home Treatment (CRHT) Team services regarding concerns relating to anxieties, frustrations and an attempt to self-harm due to stressors pertaining to her baby and her parenting role.

15.6.3 Following Angela’s suicide attempt a referral was made to the CMHT. Angela stated that she was no longer homeless and was staying with her sister. She also reported that she was having access to her baby and was engaging with alcohol support services as well as saying she was refraining from drinking alcohol. This is another agency where Angela self-reported that she was working with alcohol support services when in fact she was not. A decision was made to discharge Angela from the CMHT service however, following a conversation with the Clinicians Team Leader further clarification was requested as to whether Angela required further support from the service. This is good practice within CMHT in relation to supervision and the request for

further information prior to closure. Contact was made at the same time by Angela's HV asking whether Angela would be receiving therapy sessions. Following these reviews, a decision was made not to discharge Angela but rather to offer her intervention.

15.6.4 Due to a recognised backlog of work Angela was not allocated a worker. Angela was put on the CMHT's Active Review Team (ART) list and remained open to the service. When a patient is open to the ART they should be contacted every four weeks by the clinician however, this did not appear to take place. Subsequently the contact after the missed appointment was not activated on the system due to the first appointment not taking place. Angela was still on the waiting list when she died. The lessons relating to this have been addressed within the KMPT's IMR. During Angela's time with the service, she was discussed within their RED Board Risk management meetings. The RED (Risk, Evaluation and Decision) meeting is a daily Multi-Disciplinary Team (MDT) meeting designed to discuss patients who are experiencing an acute health episode in the community.

15.6.5 It is identified that CMHT did not attend an ICPC meeting that Children's Social Services had invited them to, nor did they send a report. By not attending this ICPC the CMHT failed to understand the importance of using a collaborative approach in meeting the patients' needs as well as identifying and managing risk.

15.6.6 Anthony was known to KMPT since 2013 predominantly relating to incidents of self-harming and suicidal ideation. Anthony identified to staff issues surrounding his diabetes and insulin dependency and also concerns surrounding housing issues. Anthony reported that he was misusing drugs and alcohol but declined a referral to CGL. Anthony was also discussed at the RED team meetings to look at the level of appropriate support to be provided to him. It was noted that Anthony appeared not to be complying with administering insulin for his diabetes and so the Clinician spoke to Anthony's nurse to make her aware and

request for follow up support. On several occasions Anthony would decline any additional treatment from services and it was noted by practitioners that he demonstrated ability to retain, understand, weigh up information and communicate decisions.

15.7 Kent Community Health NHS Foundation Trust (KCHFT)

15.7.1 KCHFT is one of the largest community providers in England serving the Kent population along with parts of East Sussex, London and Medway. The KCHFT first received a Concern and Vulnerability Notification regarding Angela whilst she was pregnant. The notification documented known health concerns surrounding Angela including previous substance misuse. KCHFT allocated a HV to Angela and her new baby who was born prematurely. The HV had numerous interactions with other Health professionals surrounding Angela and the baby and the support that could be offered to them including financial and health support. It was identified that Angela and Joseph were finding the travelling to visit the baby in hospital very difficult both emotionally and financially. The HV was notified of a strategy meeting taking place and the fact that the ICS had made the decision following a Section 47 plan surrounding Angela and the baby who was to now be stepped up from early help to a Child Protection Plan. The initial ICPC was attended by the HV where a decision was made that it did not meet the threshold as both Angela and Joseph were engaging with professionals and taking their advice on board.

15.7.2 The HV engaged fully with the CiN meetings and continued to offer support to Angela, Joseph and the baby. It is identified that the HV built up a good relationship with Angela and became the conduit between the family and other services. Upon discharge, home visits took place with the family by the HV and additionally by KCHFT's Children Therapy Service and Dietician. A Care Coordinator within the Children Therapies Team was allocated to the family due to baby's additional needs who also undertook home visits. A referral was also made for support from Portage.

15.7.3 During the home visits by the HV, conversations took place regarding the support that could be offered to the baby and the family as a whole. The HV also offered emotional support to Angela who identified that she was receiving good support from Joseph and his family. Angela's alcohol consumption was discussed, and she reported that she had not drunk alcohol for some time. Visits from the HV took place in person but also over Microsoft Teams and Angela continued to report that she had stopped drinking alcohol and had also stopped smoking. The HV recorded that she had had discussions with Angela surrounding domestic abuse but that none had been disclosed apart from a previous relationship in Spain.

15.7.4 In March 2021 the HV completed a home visit and was informed by Angela that she had been advised by Integrated Children's Services, that for the safety of the baby, she had to move out of the family home. Angela appeared upset. The HV was told to make contact with the KCHFT Adult Safeguarding Team to receive advice on the best way forward to support Angela. The HV did not make internal contact but went straight to ASC where a referral was made in relation to Angela's housing needs and not her care and support needs. This has already been identified by The KCHFT panel member as a learning point in relation to their staff gaining the appropriate safeguarding support and also making appropriate referrals. The HV also made a referral to Porchlight, GP, CGL and the Housing Officer to see if any support could be put in place for Angela.

15.7.5 On the 10th March 2021 the HV received an urgent call from Angela's sister stating that Angela had been in emergency accommodation since leaving the family home but is now in hospital having taken an overdose of medication. The duty HV contacted the hospital and spoke to Angela who indicated that she needed support in finding accommodation. The HV contacted ICS to update them on the situation. The SW indicated that she would contact the homeless persons team to see if they can give Angela some support and re-do a housing assessment, as Angela did not attend the last one due to being in hospital. The HV made contact with Angela's sister to update her of the multi-agency communication and maintained contact with Angela and

her sister. CRISIS numbers were given to Angela in case she felt she needed them at a later date. Contact was maintained with Angela and Joseph. The HV also met with Angela's GP regarding Angela and medication. These are good examples of good joined up working between agencies.

15.7.6 Angela informed the HV that herself and Joseph had decided to have a break as it was difficult to maintain a relationship due to not living together. Angela informed the HV that she found it very difficult when she visited the baby at Joseph's address as she felt that she was always being watched by Joseph's family. The HV helped Angela make a referral to We Are With You for additional support. Angela stated that she had stopped drinking alcohol. Angela appeared to use the HV as a go to point of contact in relation to contacting and gaining feedback from other agencies including the GP, Social Services and housing support organisations. The HV continued to visit the family and check on the health of the baby and the situation with Angela and Joseph. The HV also attended and contributed towards Core Group meetings. The HV again contacted Look Ahead to try and arrange support for Angela.

15.7.7 The HV received a call from Angela's brother-in-law on the 21st April 2021 stating that the situation with Angela living with them was becoming unbearable due to the limited space in the house and that Angela was now sleeping on the floor. It is unclear why the brother-in-law contacted the HV but it appears that she was again acting as the liaison between Angela and the housing professionals to try and find somewhere for Angela to live.

15.7.8 On the 4th May 2021 numerous contacts were again made with several agencies surrounding Angela. As Angela could not be contacted, the police were phoned to report her missing. A call was received by the HV from Angela's sister advising her that Angela had ended up in hospital but that she had been discharged back to her address. The HV finally spoke to Angela who stated that she had collapsed due to fatigue and had ended up in hospital having had a seizure. The HV agreed to contact the GP which led to a prescription being written for Angela. This

is another example of the HV going above and beyond her job role in order to help and support Angela. The HV continued to contact different support agencies to gain additional support for Angela including mental health support, housing support and Adult and Children Social Care.

15.7.9 Home visits also took place with both Angela and Joseph, to continue to monitor the baby. The HV attended review Child Protection Conferences and Core Group Meeting to discuss the baby and the support for both Angela and Joseph. It was noted that the baby was doing well, and that Angela was trying but was gaining little support in relation to her housing situation.

15.7.10 The HV was contacted by Joseph in June 2021 to tell her about the rape allegation that Angela had made and that he was worried about her state of mind and emotional wellbeing. The HV contact ICS and Hostel B. The support worker from the hostel contacted the HV where Angela's vulnerabilities were discussed, and it was identified that she would need a safe place to stay. A refuge was discussed with Angela who stated that she did not want to go to the ones with availability as they were too far away. Telephone conversations took place between the HV and Joseph regarding additional support for Angela and concerns regarding the allegation. Joseph also stated that he had been contacted by Anthony and told about the relationship between him and Angela and this had made him very upset. Joseph said that he would be taking the baby to see Angela to try and cheer her up as she was very down and that she had not seen the baby for about three weeks as she had been in hospital. The same day the HV received a further call from Joseph reporting that Angela had been found unconscious in her bedroom. Contact continued between the HV, Joseph and Angela's sister leading up to Angela's death.

15.8 Kent County Council, Integrated Children's Services

15.8.1 Angela and her baby were not known to ICS until September 2020 following a Request for Support (RFS) submitted by the Midwife following the premature birth of Angela's baby who was in Neonatal

care. The referral raised concerns around Angela's mental health deteriorating, citing possible isolation from the paternal family and lack of support. The front door service assessed that the referral did not meet the criteria for support at level 3 or 4[20] and Angela was offered support from an Early Help Worker. A second request for support was received from the Lead Nurse for Safeguarding Children at the hospital where the baby was. The referral cited an anonymous phone call that had been received stating that Angela used excessive alcohol. The referral also expressed concerns that Angela was an historic substance misuser and was suffering from mental health issues. Angela was visited by a SW from ICS at her home address. Angela admitted drinking during her pregnancy but that she had stopped drinking and was receiving three weekly counselling sessions organised through her GP. Further concerns were raised by the hospital around Angela's suspected drinking and as a result the case was stepped up.

15.8.2 The ICS district team felt that the concerns had met the criteria to convene a strategy discussion which took place on the 20th December 2020. In the meeting details were shared that Angela was not taking her medication and had acute financial difficulties, prioritising visiting her baby over having food to eat. A single agency Section 47 was agreed, and the outcome was to progress to an Initial Child Protection Conference (ICPC) due to concerns around housing, risk of Sudden Infant Death Syndrome, Angela falling asleep at the hospital and her alcohol usage. The plan prior to the conference was to ask Angela to complete a liver function test using hair strand and blood PEth testing. Accommodation was also offered for Angela at the hospital where her baby was.

15.8.3 The Child and Family Assessment/ICPC report highlighted Angela's needs and struggles and what she may benefit from in terms of support. It recognised the loss of Angela's mother at an early age, that she was

[20] Intensive support can be offered to children, young people and families where they have complex or multiple needs requiring local authority services to work together with universal services to assess, plan and work with the family to bring about positive change. Includes intensive family support, early help and child in need services.

a victim of interfamilial sexual abuse and was attacked whilst in Spain, all of which were contributing to her mental health needs. Alcohol abuse was also identified. Domestic abuse was also considered during the assessment but was not identified as a risk factor. The ICPC agreed that the threshold was not met, seeing the paternal family as a protective factor and support to be implemented. There is no indication that the paternal family were a part of the Child and Family assessment and no considerations given as to the interaction between the family and Angela. CGL were not invited to the conferences.

15.8.4 Grave concerns were expressed by ICS following the receipt of Angela's hair strand test which indicated a sustained and excessive usage of alcohol. This raised concerns about the honesty of Angela and family members. The subsequent Strategy Meeting decided that the paternal family were a protective factor, again without any specific analysis of their ability to protect. A decision was made to refer Angela to CGL for additional support with her alcohol abuse.

15.8.5 A further concern was raised in March 2021 surrounding Angela's ability to look after her baby following her attendance at hospital. It was recorded by hospital staff that the baby was unkempt and without his nasal gastric tube for some time. Angela was observed to be erratic and dismissive. Angela was not being supervised by the paternal family which led to concerns around possible collusion or inaction. The paternal grandmother informed the SW that she had found a bottle of vodka in Angela's bedroom. The outcome was to progress to a second ICPC regarding concerns of neglect for the baby and at the meeting held in March the baby was made the subject of a Child Protection Plan.

15.8.6 During the next three months two Core Group meetings and an ICPC review conference was held. An additional Early Help Worker (EHW) was allocated to Angela specifically to ensure she accessed appropriate services, 'to help Angela to get her back on track with her alcohol support'. The EHW made a referral for Angela to CGL with her consent and Angela confirmed that she had made an appointment for an assessment. Difficulties were identified due to access to online appointments and Angela reporting that she was struggling with her

login details. The EHW made a further referral to CGL at the end of March when Angela stated that she had not heard from CGL. The EHW made contact with Angela on six occasions throughout February and March 2021 to offer additional support. Angela moved out of the family home and the baby remained at the paternal home under the care of Joseph. ICS were notified shortly afterwards that Angela had been found at the train station under the influence of alcohol.

15.8.7 On the 10th May 2021 a Family Group Conference was held. The focus was to seek support for Angela to be able to make the necessary changes, so that she may be able to care for her baby along with Joseph, or to seek support for Joseph to continue to care for the baby alone, if the first option was unable to happen. The family made a plan that focused on the care of the baby (remaining with Joseph and the family) with supervised family time with Angela. With the hope of this becoming unsupervised as Angela progressed.

15.9 We Are With You

15.9.1 'We Are With You' is a charity which delivers substance misuse and mental health support for people experiencing mild to severe symptoms of anxiety and/or depression, nationwide. In Kent it is one of eight providers delivering Improving Access to Psychological Therapies (IAPT). Angela made a self-referral in April 2021 where her assessment indicated that she had symptoms of moderately severe depression, moderate anxiety and mild psychological distress. Angela attended her assessment appointment where she disclosed having thoughts of being 'better off dead', one to two times a month. Angela stated that she had taken a previous overdose and that she was worried about social services involvement with her family. Angela stated that she had no current plan or intention to harm herself or end her life and would not do so because of her baby. Risk management was discussed, and Angela was given information about mental health helplines and services to access in the event of a crisis or if her difficulties worsened. A safety plan was also agreed.

15.9.2 Angela stated that she was not drinking alcohol or taking drugs although said that her alcohol usage had been excessive but that she was accessing CGL for help with this and had stopped drinking. Angela disclosed that she had left the family home due to her drinking but was visiting her baby daily and hoped to increase her contact given that she was no longer drinking. Following the assessment Angela was offered and accepted a place on a Cognitive Behaviour Therapy Skills online group. Angela was unable to join the first group due to being in hospital having surgery on a burst cyst and agreed to join a new group. Angela was contacted on numerous occasions and given the options to join new groups but unfortunately no further contact was made. Angela was discharged from the service with a copy of the discharge letter being sent to her GP.

15.10 Porchlight

15.10.1 Porchlight is an independent registered charity that provides accommodation and support for single homeless people and people who are vulnerable to homelessness in the Kent area. Working across Kent and the South East, Porchlight helps vulnerable and isolated people get support with their mental health, housing, education and employment. The Porchlight outreach worker worked with Angela in May 2021 following a referral from the Borough Council and then a self-referral advising that she had had to leave her sister's address and was sleeping rough. This was verified by the worker. The referral from the Local Authority references that Angela was working with CGL to reduce her alcohol use and was waiting for an assessment to be completed by the CMHT for her mental health issues. Angela had already had an assessment for accommodation at Hostel B. Angela was a client with Porchlight for two weeks.

15.11 Look Ahead

15.11.1 Look Ahead is the commissioned service for Hostel B, they are commissioned by Kent County Council. The eligibility for Hostel B is "The service is open to vulnerable homeless adults aged 18 and over,

with complex support needs, e.g. mental health, substance misuse, trauma, who are also rough sleeping, homeless, at risk of homelessness or impacted by homelessness." The service is staffed 24 hours a day with at least two members of staff on every shift.

15.11.2 Angela made a self-referral to Hostel B and was identified as rough sleeping. She was only at Hostel B for a short period of time and during that time she also spent five nights in hospital due to a burst ovarian cyst. An assessment was completed with Angela upon her arrival at the hostel. It was raised that in the past Angela had been sexually assaulted whilst living in Spain and had experienced domestic abuse in previous relationships. No current DA was identified. Angela disclosed that she had historical issues with alcohol and was under the care of CGL. This was identified as the reason for having her baby removed and at that time was abstinent. Angela stated that she had been diagnosed with anxiety and depression and was currently taking medication and that she had made a previous suicide attempt when her baby was removed. A referral was made to Live Well Kent, the Mental Health provision commissioned by Kent County Council.

15.11.3 Anthony moved into Hostel B in September 2019, his main identified needs were around drug use, mental health and his diabetes. Staff at the hostel were aware of Anthony's criminal history with regards to theft and drug offences and that he had a probation officer. Concerning incidents of a sexual nature were highlighted to the staff whilst Anthony was a resident. Anthony's risk assessments were amended as a result of the information available.

15.11.4 Staff at the hostel were aware of Angela and Anthony forming a relationship and this was discussed individually with both of them by the therapist in regard to unhealthy attachments. The main concern from staff was that their relationship would hinder their own progress.

15.11.5 Angela reported to staff that she had been physically and sexually assaulted by Anthony and further disclosed coercive controlling behaviour by Anthony. The police were called, and a safeguarding referral was sent to social services. Anthony was arrested by the police and upon being bailed Anthony was found alternative accommodation.

15.11.6 Two days before Angela's death she was seen by the therapist within the hostel. She was asked explicitly about suicide ideation. She said that she had no plans made, with her baby being the strongest reason for this. Angela's risk assessment was updated. Angela later reported to staff that she had been receiving messages from Anthony via Facebook saying that she was a liar. Staff gave advice to Angela and stated that they would try and stop the messages and would report the matter to the police. They did this but not until two days later.

15.11.7 Angela took part in an outdoor yoga session and was seen by the therapist. Several staff expressed that she seemed to be in good spirits however later that day she attempted to take her own life and was taken to hospital where she sadly died a few days later.

15.12 **Kent Police**

15.12.1 Kent Police were made aware of an allegation of rape relating to Angela from staff at Hostel B. The information was that she had moved into the hostel a week previously and had met Anthony and started a relationship with him. Their relationship was of a sexual nature which was consensual however Angela stated that Anthony had later forced himself on her and identified coercive controlling behaviour. Anthony was arrested at the hostel and later bailed and given conditions not to return to the hostel. A Domestic Abuse Risk Assessment (DARA) was undertaken which was graded as high. A safeguarding review took place, and a MARAC referral was submitted in June 2021. The police were also notified that Anthony had breached his bail conditions by posting messages for Angela on the hostel Facebook page. Angela was not spoken to about these messages by the police prior to her death.

15.12.2 The police were then called to Hostel B after Angela was found unconscious in her bedroom by hostel staff. A report was completed for the Coroner.

15.12.3 The police have several records relating to Anthony, mainly involving theft and drugs. The police identified a theme that Anthony has issues around relationships particularly when they fail, which lead to allegations of harassment by both parties. There are also examples of sexualised behaviour. Anthony's relationships involved people who at face value are as vulnerable as Anthony would appear to be. Anthony is known to have make threats to take his own life and has a history of coercive and controlling behaviour.

16 Key Events Analysis

The analysis is divided into three separated time frames:

1) The birth of the baby and Angela's recognised mental health concerns including alcohol dependency.

2) Angela moving out of the family home and leaving the baby with the biological father and his family, and her initial suicide attempt.

3) Angela moving into Hotel B and her relationship with Anthony.

16.1 The Birth of the Baby and Angela's Recognised Mental Health Concerns Including Alcohol Dependency

16.1.1 Angela and Joseph's baby was born prematurely in hospital aged 24+4 weeks' gestation. Giving birth to such a premature baby would have been a very stressful and frightening experience for Angela. It was known to professionals that Angela had previously diagnosed mental health issues including suffering from anxiety and an eating disorder, Bulimia. Angela's medical records also recorded that she had a history of drug and alcohol dependency. The additional stress upon Angela following the birth of her baby was not recognised by all professionals. During the time that the baby was in neonatal care, Angela's mental

health was observed to be very fragile. She was often observed to be anxious, upset, and tearful and acknowledged that she might have been suffering from post-natal depression. Suspicions were raised by staff on several occasions that Angela may have been drinking alcohol excessively. When they asked Angela she denied that she had been drinking alcohol. Angela was signposted to services that could offer her support for alcohol dependency problems however, these were not followed up by staff.

16.1.2 On several occasions Angela was observed to fall asleep at her baby's cot side by hospital staff. Angela reported to staff that Joseph was very supportive of her but that he did not understand post-natal depression and the effect this was having on her. Hospital staff did discuss domestic abuse with Angela and she did not state any abuse between them. Angela was offered two weeks' hospital accommodation whilst the baby was there which appeared to help Angela but it has been identified that this could have been considered at an earlier stage to take the mental, physical and financial strain off of Angela.

16.1.3 A referral was made to ICS regarding concerns that hospital staff had surrounding Angela and possible alcohol problems. This included receiving a call to the hospital when the baby was born stating that Angela drank excessively during her pregnancy and concerns that she was drinking during her visits to see her baby. There is no reference to any family member being spoken to regarding the phone call made to the hospital. These conversations might have opened the door to having a frank conversation with Angela and the family unit regarding her alcohol intake both during and after the birth of her baby. A referral was made to ICS regarding concerns of Angela's ability to care for the baby. The referral was of an appropriate nature and was followed up by ICS. Upon being spoken to, Angela informed ICS that she had drunk alcohol during her pregnancy but that she had ceased drinking three months ago. The information provided by Angela is contrary to her liver function test as well as observations from staff whilst she was visiting the baby in hospital.

16.1.4 Throughout the review period it is identified that several agencies had conversations with Angela regarding her alcohol dependency and the referral process to gain help and support. On nearly all the occasions, including conversations with her family, Angela reported that she was engaging with CGL and that she had a support worker. This has been identified as not being the case and the two referrals received by CGL were not acted upon following conversations with Angela who informed them that she had stopped drinking and therefore did not need any additional support. Professionals were very quick to accept the information given to them by Angela without any follow up. It appears that during the ICPCs, follow up meetings and Core Group meetings it was identified that Angela was receiving support from CGL. If this had been followed up or CGL invited to attend the meetings, then it would have shown that in fact Angela was not accessing support. It has been identified that agencies were very quick to accept information and were not aware of the impact alcohol has on people and the lengths some alcohol dependent people will go to, to divert attention from their alcohol dependency. It was also considered that Angela might have thought she was being supported by CGL as she was in contact with a number of services.

16.1.5 Camille, Renzoni, The Recovery Village identifies that 'If someone close to you, like a family member or significant other, develops an alcohol addiction, you may notice that they behave differently than they usually do. The signs of alcoholism and alcohol use disorder often include problematic physical and behavioural changes like avoidance, defensiveness, and lying. Lying to loved ones is a common sign of alcohol addiction and substance use disorders involving other drugs, too. You might be aware of the lying, but you might be wondering why they'd lie, and be frustrated that they do not seem to see that you want to help them. In a society that stigmatizes alcohol abuse and addiction, people who struggle with alcoholism may try to hide or cover up their disease to avoid judgment, among other reasons. For many alcoholics, lying is a defence mechanism that maintains the disease of addiction, and ultimately, lying is a roadblock on the path to recovery'[21].

[21] https://www.therecoveryvillage.com/alcohol-abuse/faq/why-alcoholics-lie/

16.1.6 Good support was given to Angela in relation to concerns expressed surrounding her mental health and post-natal depression. Angela was discussed at a multidisciplinary team meeting where a decision to make a referral to Adult Social Care was made, and also for support to be offered to Angela. It is unsure as to whether this referral was a safeguarding referral or a referral for assessment of care and support needs under the Care Act 2014. There is no documented outcome regarding this referral. Angela was seen by the Specialist Mental Health Midwife who discussed her level of stress and anxiety. Support for housing, and mental and emotional wellbeing was discussed. A referral was made to the Neonatal Outreach Admission to Home (NOAH) team for home support. It was also identified that Angela had been accessing counselling support from her GP. Although it has been identified that a high level of mental health support was offered to Angela it was also identified that this must have, at times, been confusing for her and would have added to the pressure that she was feeling. There does not appear to be any joined-up approach discussed or consideration to gaining information from those services who were talking to Angela to see if they were appropriate. Agencies, although working hard to support Angela were often doing so in silos.

16.1.7 The support provided to Angela, Joseph and the baby by the Kent Community Health NHS Foundation Trust, predominantly through the HV and Children's Therapy team, was of a particularly high standard. There is significant evidence within their IMR that both Angela and Joseph had a good relationship with the HV and that they utilised her for her professional support. The HV went over and beyond her role to support Angela and the family with the many challenges and vulnerabilities over the period of the review. However, it is acknowledged by the KCHFT IMR writer that some of the work carried out by the HV should have been communicated with the Social Worker and the boundaries of support may have been blurred. Both Angela and Joseph and ultimately Angela's family, would contact the HV in the first instance and there were times where the HV should have contacted the SW for support.

16.1.8 During the ICPC and Core group meetings consideration does not appear to have been given as to whether a Mother and Baby unit[22] could have been an option for Angela and the baby. This could have enabled an assessment and treatment of her mental health as well as subsequent parenting assessments. There is no evidence of any parenting support for her or any assessments that determine her ability. The focus was very much upon her alcohol and mental health which could have been address alongside her parenting capacity. Having discussed the MBUs within the panel meeting it was considered that Angela's mental health problems would not meet the threshold for a placement.

16.1.9 During the time that the baby was being identified as a Child In Need the emphasis was placed upon Angela's alcohol dependency and concerns as to her ability to look after her baby. Hair tests have helped social workers with difficult child protection cases involving parental substance misuse. Parental substance abuse remains a huge factor when it comes to putting children at risk in the UK. Research last year by Alcohol Concern and the Children's Society estimated that 2.6 million children in the UK live with a parent whose drinking could lead to neglect or abuse. For social workers it is notoriously difficult to know whether a parent who claims to have kicked their habit is being truthful and whether their new, reformed lifestyle can survive temptation. As a result, social workers are becoming more reliant on hair strand-testing to profile patterns of drug and alcohol use[23]. The CiN plan was reflected upon by the ICS IMR writer who acknowledged that the initial plan was borne out of the ICPC. The plan revolved around Angela's alcohol dependency and evidence surrounding how the family could protect the baby. Ways to support Angela were lacking. In relation to CiN plans parents should be asked if they consent to a child and family assessment being undertaken and any subsequent social work

[22] A Mother and Baby Unit (MBU) is specialist inpatient treatment unit where mothers with mental illness are admitted with their babies. In MBUs, mothers experiencing postpartum psychosis can be supported to care for their babies whilst having the specialist care and treatment they need.
[23] Ben Willis on March 18, 2011 in Child safeguarding, Substance misuse

intervention. In this case the family did consent as it was recorded that Angela wanted to do whatever she could for the benefit of her baby. The ICS did not make a referral to ASC as part of the child protection plan. As Angela had care and support needs, this may have taken a more strength based and holistic approach in safeguarding the family.

16.2 Angela Moving Out of the Family Home and Leaving the Baby with the Biological Father and his Family and her Initial Suicide Attempt

16.2.1 Following the ICPC in March 2021 a decision was made for the baby to be made a subject of a Child Protection Plan under the category of Neglect. Professionals continued to work closely with Angela, Joseph and the baby. However, three months after the plan was initiated Angela moved out of the family home leaving the baby in the care of Joseph and his family. Several agencies, including Joseph, reported that Angela had been told by the ICS SW that she needed to move out of the home. There is a suggestion from the family, that Angela was also told that unless she moved out the baby would be taken into care. The ICS SW states that it was a family decision following advice from them regarding the level of risk posed to the baby. The main issue is to look at the level of support offered to Angela as a result of moving out of the home. ICS's main role is to protect children and as such their main responsibility was towards the baby however, as professionals they still have a responsibility to make sure that Angela is safe and well.

16.2.2 ICS did in fact bring another Early Help Worker on board to work with Angela to ensure that she accessed the appropriate counselling services, provided support in relation to housing and also made a referral to CGL for support for her alcohol dependency. This is good practice and demonstrates that Angela's needs were considered. The ICS report identified the need for a lead person for Angela, as there

was a heavy reliance in Angela self-reporting to different professionals. A medical detox was also considered for Angela; however, this was not felt to be appropriate at that time. In supervision records relating to Angela and the baby, the fragility of Angela was mentioned including her alcohol use and mental health issues.

16.2.3 During ICS's work with Angela it was felt that she had a real desire to be a good mother but that her addictions and behaviours due to her lived experiences were overwhelming. The impact of all of Angela's vulnerabilities, health matters and addictions are identified within the ICS's IMR as an area that needed more understanding. No referrals were made to Adult Social Care, not even after Angela's suicide attempt which was a missed opportunity. The SW did not fully appreciate the consequential impact leaving the family home and the baby had on Angela. There was a great deal of good practice such as joined up working between agencies in relation to the baby. However, this level of joined up support was not in place for Angela. In Kent and Medway all the NHS organisations and the Kent and Medway councils have been working together as a sustainability and transformation partnership (STP) since 2016. In April 2021 NHS England formally accredited Kent and Medway as an Integrated Care System. An integrated care system approach is when all organisations involved in health and social care work together in different, more joined-up ways. The focus is on providing care in a way that benefits patients - not what is easiest for organisations[24]. It has been identified that there may be a need for development and opportunities to support ICS to increase their knowledge around how to work more effectively with Adult Social Care. The ASC IMR also highlighted the need for Adult Social Care to engage with Children's Social Care, to ensure care is wrapped around the individual.

16.2.4 There is no evidence that the multi-agency professionals considered Angela's past experiences and traumas which could have formed a trauma informed approach. There was a missed opportunity for Angela to be assessed under the Care Act 2014 in her own right. Supporting

[24] https://www.kentandmedwayccg.nhs.uk/about-us/who-we-are/ICS

People with Adverse Childhood Experiences (SPACE) matters is a collaborative project across Kent and Medway to prevent and reduce the impact of ACEs. Kent County Council's vision is to support trauma informed working across a wide range of professional settings and services.

16.2.5 Adverse childhood experiences (ACEs) are some of the most intense, and frequently experienced, sources of stress that children may suffer early in life. They include multiple types of abuse including:

- Neglect
- Violence between parents or caregivers
- Alcohol and substance abuse
- Peer, community and collective violence

Global research consistently shows an association between multiple ACEs and health harming behaviours, physical and mental health in adulthood. The strongest associations are seen between violence perpetration and victimisation, mental ill-health and substance misuse.

16.2.6 Following Angela's suicide attempt another assessment was undertaken by ICS. The Child and Family Assessment and conference report was updated and rightly the focus was the risk to the baby however, the impact of Angela being separated from her baby was underestimated especially given her level of vulnerability. KSCMP have recently published a report which highlights the impact of parental mental health on children and highlights the point that 'Children should never be considered as a protective factor for parents who feel suicidal or have mental health issues'. What professionals should have considered was the risk factor to Angela of not being with her baby.

16.2.7 During Core Group meetings and subsequent ICPC meetings the concerns raised were surrounding Angela's alcohol problems and the impact that this had on her ability to care for her baby. One of the main protective factors put in place was for the paternal grandmother to support Angela with the care of the baby. There does not appear to

have been any in depth assessments around the relationship between Angela and the paternal family. There are conflicting reports from Angela that she was feeling supported by the family but also that she was made to feel uncomfortable and that she was being spied upon. Domestic abuse within the household was not considered nor whether the relationship between Angela and the paternal family was of an abusive nature. Concerns were raised that family members were complicit in Angela's drinking however, this was not explored further. Following the decision that Angela was to move out of the family home there appears to have been little consideration as to the family dynamics and the impact that this would have on Angela. Angela would have to visit her baby at their address after being asked to move out due to alcohol dependency problems. There is little understanding of the nature of the relationship between Angela and Joseph's family and how supportive, or not, they were.

16.2.8 Angela had limited involvement with Adult Social Care. The initial referral sent by the HV was received into ASC in March 2021 at the time that Angela left her family home. The referral stated that Angela had left her baby with her partner and his family after being advised to do so by ICS. The level of the impact of Angela leaving her baby does not appear to have been identified as an area of concern and was therefore not treated with sufficient urgency. The issue of Angela's vulnerabilities was highlighted, she had Stevens-Johnson Syndrome, her mother had died at an early age, she was homeless, had recorded alcohol dependency issues and multiple agency involvement. However, the seriousness of concerns identified by the HV was not sufficiently reflected within the referral and there was no indication of what the HV expected to happen as a result of the referral. The referral mainly touched on Angela's housing needs and therefore the level of Angela's vulnerabilities was lost. It was highlighted within the DHR panel meeting that additional support and training is being given to

agencies regarding the making of an appropriate referral including what information they should contain and what action is required from ASC. A briefing document has already been produced by KMSAB[25] which clearly shows why good referrals are necessary and what makes a good referral.

16.2.9 The initial referral into ASC from the HV was updated following the incident at the train station where Angela, having been found intoxicated, was taken to hospital and the subsequent suicide attempt. A referral to the Kent Enablement and Recovery Service (KERS) was made and Angela was offered a duty screening appointment. She spoke to the Duty Social Worker following this telephone contact. However, the information on Angela's records do not contain sufficient evidence of her needs, and the rationale for follow up action was not included. The referral to KERS took 12 days and as such this was a missed opportunity to engage with Angela and provide the necessary support. Angela was not screened for MH Social Care until 22 days from the date of the referral. There were identified missed opportunities to engage Angela and to assess initial risks towards her and for agencies to have worked more closely together to provide support. A multi-agency meeting could have been called by any of the involved agencies at an earlier point in Angela's journey. This would have given her the opportunity to engage in the support that she needed.

16.2.10 It must be reflected that this was during the pandemic and as such there was a delay in KER's service involvement. ASC have identified new daily triage processes that have been put in place to capture referrals within a 24/48hr timeframe.

16.2.11 There are published reports[26] relating to alcohol use and safeguarding which identify methods of improving care as; better multiagency working, stronger risk assessments and improved

[25] Understanding what constitutes a safeguarding concern and how to support effective outcomes | Local Government Association

[26] https://alcoholchange.org.uk/publication/learning-from-tragedies-an-analysis-of-alcohol-related-safeguarding-adult-reviews-published-in-2017

understanding and training for practitioners. This would help them better identify and support, in a non-stigmatising way, vulnerable people who are experiencing alcohol harm. This is an area that could benefit from improved multi-agency procedures.

16.2.12 A major point of concern and frustration identified by the family was the impact of housing when Angela moved out of the family home. As a result of her suicide attempt Angela's sister was contacted by ICS as to ask whether Angela could stay with her for a while whilst suitable accommodation was found. This unfortunately led to Angela living with her sister and her family for several months. Following a homeless application Angela was again hospitalised which resulted in another stay with her sister. Angela approached the Borough Council Housing department in March 2021 at the point of being made homeless. She advised that she had been asked to leave the family home by Social Services, due to her drinking and not being able to care for her baby. The Borough Council made contact with ICS who confirmed the circumstances of why Angela left the home. A vulnerability assessment was undertaken with Angela where it was identified that she did not meet the criteria for a priority need for housing. Angela's assessment was reviewed following notification of her suicide attempt where a referral was made on her behalf to Porchlight and supported housing. The assessment identified that Angela had substance misuse issues and a history of mental health illness. Following her assessment, she was assessed as not facing any more harm than the ordinary person faced with the same situation, which is the homeless test that would have given the Borough Council a reason to believe that she had a priority need. It was identified that appropriate services were offered to Angela including referrals for supported housing and support for debt and budgeting.

16.2.13 It has been acknowledged throughout the review and is also being highlighted within the media the lack of suitable housing within Councils. There is a significant gap of suitable housing for those adults with complex needs and as such an inordinate amount of pressure is being placed on Councils to place adults in

accommodation which is often unavailable and unsuitable. The Local Government Association LGA have identified that "The housing shortage is one of the most pressing issues we face. Councils have a key role in delivering more affordable housing and help to build 300,000 new homes a year". Councils across the country are facing the same additional pressures and at this time there are limited options available to Councils.

16.3 Angela Moving into Hostel B and her Relationship with Anthony

16.3.1 Hostel B is a single 14 bed hostel. People can stay for up to two years. They are supported by a key worker for any presenting needs such as substance misuse and mental health as well as supporting people to gain independent living skills so that they can move on and sustain a tenancy. Hostel B is to support adults of mixed genders that are single, homeless and with complex needs. The building/housing is funded through housing benefit. Both Angela and Anthony's referrals into the service would have been seen as suitable referrals and one of the only available options for them. Since 2003, Kent County Council has commissioned a range of prevention and support services for adults with support needs that are also facing homelessness. The hostel panel member identified that KCC were currently in consultation surrounding withdrawing their funding for Hostel B and similar provisions within Kent from September 2022. It is unknown what future provisions would be put in place to house homeless single adults with complex needs and vulnerabilities. The Council has made a commitment to provide transitional funding after the contract has ended, at least until the end of 2022/23 financial year so that arrangements can be made with other organisations and councils to find new ways and funding to provide support to service users in the future[27]. The Chair met with the Housing Solutions Manger who identified that transitional planning between Kent County Council, Districts and Services is currently in place. The Districts have

[27] Kent Homeless Connect Consultation | Let's talk Kent

a statutory responsibility in relation to homelessness and there is a huge shift towards prevention. The IMR writer for Hostel B identified that if Angela had not been accommodated at the hostel, she would have continued to be rough sleeping. Although it was identified that Angela would have been much more suited to a female only provision, there are no such options in Kent and as such Hostel B was a suitable alternative. After the rape allegation a refuge was offered to Angela, but this was declined due to the distance from her family.

16.3.2 Hostel B identified that the referral and assessment process that takes place with a new client, in the case of a self-referral, can lack key information and solely relies on information presented by the client themselves which may not always be forthcoming. It was known that a number of professionals were involved in Angela's care however, these were not contacted as a part of the assessment process which could have been the beginning of a joint working partnership between health care professionals and the service. Risk assessments are completed every three months as a minimum, although some will be completed more frequently depending upon the individual, and if any incidents trigger a need for a review. The panel member identified that the risk assessment reviews had become more of an incident logging system, and the risk the person posed to themselves and others was often not reviewed or updated. One of the recommendations from Hostel B's IMR is to review the risk assessment process.

16.3.3 The Police and Hostel B have an Information Sharing Agreement and the local district Community Safety Unit (CSU) manage this information flow. The agreement is in place to carry out police checks on referrals before they move into the hostel. This is to highlight any history of serious crime and violence that would make it unsafe for them or anyone else residing at the hostel. The markers for this are any past or pending convictions for: arson, sexual assault, extreme violence towards professionals and anything that would impact on

living in shared accommodation. This information was requested for both Angela and Anthony however, nothing was declared for either party. There were also no disclosures surrounding previous domestic abuse for either party.

16.3.4 During Anthony's time living at the hostel three separate incidents of a sexual nature were identified by staff. It appears that risk assessments surrounding Anthony were updated following receipt of this information however, there does not appear to have been any impact on him continuing to live there. This information was also not shared with Anthony's Probation Officer who used to have meetings with staff from the hostel. This information should have been shared with other professionals so the level of risk that Anthony posed to females could have been properly assessed. The panel member from Hostel B pointed out that residents at the hostel all had backgrounds of complex needs and the majority had alcohol and drug dependency problems. This is what the nature of the hostel is, to provide support for people with complex needs. It is however felt that when the relationship between Angela and Anthony started, the level of risk Anthony potentially posed should have been assessed and actions taken to try and mitigate those risks. Staff on site were aware of Angela and Anthony forming a relationship. This was discussed with them both individually by the therapist in regard to unhealthy attachments.

16.3.5 The hostel has a therapist on site who is utilised well by residents. Angela was referred to the in-house therapist during her stay at the hostel. The therapist indicated that Angela showed examples of irrational behaviour whilst staying at the hostel. During her initial assessment Angela discussed her previous attempt to take her own life but stated that her relationship with her baby means she would not do so again. Angela did not disclose any other relationship with counsellors or therapists, just saying that she had had a negative experience of counselling in the past. The therapist was only able to

have one formal session with Angela which was on the day Angela had earlier made the disclosure about Anthony raping her. It was identified by the therapist that deep rooted trauma was resurfacing within Angela.

16.3.6 From her observations the therapist stated that both Angela and Anthony were demonstrating destructive relationship patterns. The therapist wrote that Angela and Anthony had quickly become infatuated with each other which might have been an indication of Anthony's controlling behaviour. Anthony's previous offending history shows a propensity towards sexualised coercive controlling behaviour. This manifested itself with allegations of stalking and harassment made against and by Anthony. In 2019 Anthony pleaded guilty to an offence of harassment following allegations of stalking and harassment and received a Community Order. In 2013 he received a caution for sending texts to a previous ex-girlfriend. There are also the three incidents whilst Anthony was living at the hostel, of a sexualised nature towards females. The police have common law powers to disclose information about a person's known history of violence or abuse, normally relating to previous convictions or charges, to the public where there is a pressing need for disclosure of the information in order to prevent further crime. The principal aim of the Domestic Violence Disclosure Scheme (DVDS) is to introduce recognised and consistent procedures, based on this common law power, for the police to consider the disclosure of information in order to protect a member of the public who may be at risk of harm from domestic violence or abuse. Critical to the success of the scheme is the need for a risk assessment to be completed at every stage in the disclosure process, as this will inform the practical actions necessary to safeguard the potential victim and inform the development of a potential disclosure under this scheme.

16.3.7 The Domestic Violence Disclosure Scheme recognises two procedures for disclosing information:

"Right to ask" is triggered by a member of the public applying to the police for disclosure.

"Right to know" is triggered by the police making a proactive decision to disclose information to protect a potential victim[28].

16.3.8 It is very difficult to see in Angela's circumstances whether this scheme should have been considered in this case due to the very short amount of time that Anthony and Angela were in a relationship. The police, nor any other agencies, apart from hostel staff, were aware of the relationship between Anthony and Angela until the rape allegation. The DVDS is something that professionals need to be aware if similar circumstance happen to arise.

16.3.9 The police's IMR writer recognised that serial perpetrators are not being identified and referred for consideration as a Potentially Dangerous Person[29] or for multi-agency intervention. Such action may assist in disclosure to other potential victims.

16.3.10 The therapist viewed that a mixed sex hostel is not the right environment for someone, such as Angela, who had experienced such a level of trauma at an early age. Kent have no single sex hostels for single homeless people with complex needs. The only single sex provision are women's refuges which Angela did not meet the criteria for when presenting as homeless, and later declined the places offered at refuges outside of the county.

16.3.11 Upon making the rape allegation Angela was dealt with in an appropriate manner. A DARA Risk Assessment was undertaken which was graded as high. A Safeguarding referral was made. A Multi-Agency Risk Assessment Conference (MARAC) referral was made however, it has been identified by the police's IMR writer that this was not until six days later which has been identified as an individual lapse. Angela attended the Sexual Assault Referral Centre

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28 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575361/DVDS_guidance_FINAL_v3.pdf

29 A potentially dangerous person (PDP) is a person who has not been convicted of, or cautioned for, any offence that places them into one of the three MAPPA categories but whose behaviour gives reasonable grounds for believing that there is a present likelihood of them committing an offence that will cause serious harm

(SARC) where a referral was made for support from an Independent Sexual Violence Advisor (ISVA). There does not appear to have been a referral to an Independent Domestic Violence Advisor (IDVA) by either the police or workers within Hostel B even though Angela had reported instances where Anthony was displaying coercive controlling behaviour towards her. There appears to be some confusion between the two services. Hostel B have a DA Champion within their service who would be responsible for completing a referral however, at the time there was not one available to the service.

17 Conclusion

17.1 A study completed by the American Journal of Epidemiology 'Mortality Among Mothers Whose Children Were Taken Into Care by Child Protection Services: A Discordant Sibling 2018'[30], examines whether mothers who had a child taken into care by child protection services have higher mortality rates compared with rates seen in their biological sisters who did not have a child taken into care. The research identified that there were an additional 24 deaths per 10,000 person-years among mothers who had had a child taken into care. The higher mortality rates, particularly avoidable mortality, among mothers who had a child taken into care indicate a need for more specific interventions for these mothers.

17.2 When children are taken into care by child protection services, the safety and well-being of the child are the highest priority. This process often overlooks the health and well-being of the mother. Previous studies have found that mothers who had a child taken into care often have more health issues and social instability than mothers in the general population; these challenges worsen after their child is taken[31]. The distress that a mother faces after a different type of loss, the death of a child, is publicly acknowledged and has been linked with many health consequences, such as increased mental illness and heightened mortality[32]. Recent findings indicate that

[30] https://academic.oup.com/aje/article/187/6/1182/4956003

[31] Wall-Wieler E, Roos LL, Bolton J, et al. Maternal health and social outcomes after having a child taken into care: population-based longitudinal cohort study using linkable administrative data. J Epidemiol Community Health. 2017

[32] Li J, Laursen TM, Precht DH, et al. Hospitalization for mental illness among parents after the death of a child. N Engl J Med. 2005

mothers who had lost custody of a child through child protection services have higher rates of mental illness following separation from their child than mothers who experienced the death of a child[33]. While mothers who had a child taken into care have higher rates of suicide attempts and completions, it is not known whether there is a higher rate of mortality among mothers from other causes after losing custody of a child[34].

17.3 Mothers involved with child protection services often face stigma; many have been accused of abuse or neglect and have not met society's ideal of what constitutes good parenting[35]. Public health interventions that provide more stability and address the unique health-care challenges of individuals (both mothers and children) involved with the child protection services could reduce rates of premature mortality.

17.4 Although Angela's baby was not taken into care, the fact that Angela and the family were advised that Angela could not remain at home with her baby, would appear to have had the same impact upon Angela's mental health. Angela did receive mental health support, but this was at the time of a crisis and there was limited long term support. Although support was put in place for Angela, including an additional Early Help Worker from ICS, it was identified that professionals did not fully understand the impact on Angela of being separated from her baby, especially as she had identified additional care and support needs. The level of risk to Angela following her suicide attempt did not seem to have an impact upon the support that agencies gave to her. There appeared to be an emphasis on Angela accessing support services with limited knowledge of the impact her alcohol addiction had upon her. There also seems to have been limited identification of the link between the impact of trauma on Angela and her mental health. There was a lack of a trauma-informed approach across agencies in their engagement with Angela, and a lack of understanding of her vulnerabilities, health matters and addictions.

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[33] Wall-Wieler E, Roos LL, Bolton J, et al. Maternal mental health after custody loss and death of child: a retrospective cohort study using linkable administrative data
(published online ahead of print October 29, 2017)

[34] Wall-Wieler, E Roos LL, Brownell M, et al. Suicide attempts and completions among mothers whose children were taken into care by child protection services: a cohort study using linkable administrative data Can J Psychiatry 2018

[35] McKegney Si*lenced Suffering: the Disenfranchised Grief of Birthmothers Compulsorily Separated From Their Children* 2003

17.5 Angela was initially assessed by We Are With You, including a clinical interview and completing a clinical questionnaire. The assessment was based on mental health issues and past history. Risks were indicated and Angela stated during the assessment that she thought that she would be 'better off dead', and those thoughts would occur once or twice a month. This assessment took place following Angela's initial attempt to take her own life.

17.6 Recent news reports[36] have highlighted the risks associated with professionals completing risk assessments. According to the latest official data[37], 6,211 people in the UK killed themselves in 2020. It is the most common cause of death in 20-34 year olds. It has highlighted that of the 17 people each day, on average, who kill themselves, five are in touch with mental health services and four of those five are assessed as "low" or "no risk". Philip Pirie, who sadly lost his son Tom in July 2020, identified that Tom had been seen by a counsellor, for mental health concerns, and he had been assessed as low risk of suicide the day before he took his own life. Mr Pirie is campaigning to overhaul the system for assessing suicide risk. In July 2020, a Royal College of Psychiatrists report[38] concluded the approach to suicide risk assessment was "fundamentally flawed" and the use of terms such as "low risk... unreliable, open to misinterpretation and potentially unsafe". Using scales or ratings could provide false reassurance, it said, especially when suicidal thoughts could vary significantly across a short time period. In Angela's case she did receive a clinical assessment as well as an online assessment which supports the risk assessments.

17.7 NICE (National Institute for Health and Care Excellence) guidelines[39] advise staff not to use risk-assessment tools to predict suicide, though identify that they can be helpful in developing a safety plan.

17.8 The Borough Council Housing missed an opportunity of reviewing and updating the suitability and vulnerability assessment, especially due to

[36] https://www.bbc.co.uk/news/health-61154248
[37] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2020registrations
[38] https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr229-self-harm-and-suicide.pdf?sfvrsn=b6fdf395_10
[39] https://www.nice.org.uk/donotdo/do-not-use-risk-assessment-tools-and-scales-to-predict-future-suicide-or-repetition-of-selfharm

Angela's attempt to take her own life. It has been identified that sometimes clients are too worried to tell the Housing Team everything in fear of being turned away. However, this would not be the case, instead they would become more of a priority. Angela was specifically asked about domestic abuse (which she did not disclose) which is good practice.

17.9 The 2021-2025 Suicide Prevention Strategy in Kent and Medway[40] identifies that in order to reduce suicide and self-harm in Kent and Medway as much as possible they have adopted the six priorities from the national suicide prevention strategy and adapted them for local circumstances. Their priority one is to reduce the risk of suicide in high priority groups. The strategy identifies "We will also work with all relevant partners on specific projects to reduce the risk of suicide and self-harm in high-risk groups including but not limited to:

- Middle aged men
- People with previous suicide attempts/self-harm
- People known to secondary mental health services
- People who misuse drugs and alcohol
- People who are impacted by domestic abuse
- Children and young people
- New high-risk groups as identified by real time suicide surveillance"

17.10 Consideration is to be given to including mothers who have had their children removed from their care either by ICS or on a voluntary basis and to include being placed with other family members.

17.11 The recent Health and Social Care Secretary Sajid Javid recently spoke regarding suicide prevention and identified that "As well as looking at those communities at greatest risk, we must also look at the risk factors that lead to suicides across all communities. We know that the causes of suicide are complex and intertwined but the data does show that there are some areas where we can have a big impact. For example, there is a project in Kent that found that 30% of all suspected suicides in a 2-year period was linked to

[40] https://www.kent.gov.uk/__data/assets/pdf_file/0010/130969/Kent-and-Medway-Suicide-and-Self-harm-Prevention-Strategy-2021-25.pdf

domestic abuse. Our new plan will look at risks like domestic abuse and gambling, as these weren't looked at in the previous strategy"[41]. This identified the good work that is currently taking place in relation to suicide prevention in Kent.

17.12 Due to the amount of time that Angela and Anthony were in a relationship there was no information received by professionals surrounding domestic abuse between them. Following the rape allegation Angela also identified instances where Anthony had been controlling toward her. These included following her to the toilet and not letting her out of his sight. Upon making the rape allegation professionals acted well in supporting Angela and the appropriate referrals for support were made.

17.13 Agencies have identified within their IMRs that they did not feel on any occasion that Angela was lacking the capacity to make decisions and as such Mental Capacity Act Assessments were not considered necessary. Having mental capacity means that a person is able to make their own decisions. An assessment is designed to empower and protect an individual who may be unable to make a decision because the way their mind or brain works is affected, for example, by illness or disability, or the effects of drugs or alcohol[42]. Agencies did not feel that Angela's use of alcohol impacted so greatly on her that it impeded her capacity to make her own decisions.

17.14 All agencies that took part in the review process have up to date policies and procedures in place for Domestic Abuse, Stalking and Harassment and current risk assessments. The risk assessments were used by agencies however, as already stated the impact of the risk was not always identified. Within Hostel B's IMR the writer highlighted that although training surrounding safeguarding was mandatory for their staff this was not the case for training on domestic abuse. They did identify that training was available for their staff and that many had completed the training despite it not being mandatory.

[41] https://www.gov.uk/government/speeches/health-and-social-care-secretary-of-state-speech-on-suicide-prevention - :~:text=As well as, the previous strategy

[42] https://www.scie.org.uk/mca/practice/assessing-capacity

17.15 The impact of COVID-19 was discussed within the panel and although professionals stated that it did change the way their staff worked, they did not feel that it impacted on the level of support that was made available to Angela.

17.16 Anthony's vulnerability was also discussed at the panel meeting and concerns were raised regarding his care and support needs. A decision was made that a multi-agency meeting would be held to discuss Anthony and to look at any additional support required.

17.17 It was identified that Angela had complex needs and was experiencing multiple disadvantages. Kent and Medway have processes in place where individual professionals can call a multi-agency meeting to support the person. They are currently developing the Multi-Agency Risk Management Framework (MARM)[43] process which is intended to be considered for individuals who either decline to engage, or present with significant barriers to engage, with complex or diverse needs and can be used to either support existing multi-agency forums, or as a separate framework. MARM is currently out for consultation.

18 Learning Points and Recommendations

Agencies within this review have identified their own individual recommendations. This will be monitored by the individual agency and signed off when completed.

18.1 Support Around People Who Are Alcohol Dependant

18.1.1 It was highlighted throughout the review that Angela identified to several agencies and family members that she was working with CGL in relation to her alcohol dependency issues. Two referrals were made to CGL by agencies, following consent from Angela. However, when contacted by CGL Angela stated that she had been alcohol free for several months and therefore did not need support from their service. Angela was signposted to different support services within the

[43] Multi-Agency Risk Management Framework (MARM). This framework has been designed to support working practice for anyone working with an adult where there is a high level of risk of harm, and the circumstances sit outside the statutory adult safeguarding framework, but where a multi-agency approach would be beneficial.

community and was told to contact CGL again if she felt she needed any support. Angela was then closed to CGL. Agencies appeared to be happy to accept that Angela was receiving help for her alcohol addiction without any follow-up or clarification. The impact of the work between Angela and CGL would have been significant in relation to the ICPC and Core Group meetings surrounding the baby and ultimately to the decision made for Angela to leave the family home due to her alcohol dependency. Neither attendance or reports were requested from CGL for the Child Protection meetings and agencies were happy to accept the account given by Angela.

18.1.2 Other agencies involved with Angela also believed that she was accessing support from CGL but no contact was made with the service. The Early Help Worker from ICS who had been allocated to support Angela at the time she left her baby and moved out of the family home, made no contact with other services. Mental health services did not speak to Angela regarding the support she was receiving and whether the support was of an appropriate nature. Professionals did not use sufficient professional curiosity regarding the support Angela was receiving and appeared to accept the facts given to them. Again, it was identified that perhaps agencies had not received sufficient training surrounding adults who are substance dependent and the impact this substance abuse might have upon them and the lengths some alcohol dependent people will go to, to divert the attention away from their alcohol usage.

18.1.3 Rates of hospital admissions related to alcohol have been increasing in recent years in Kent – from 320 per 100,000 population in 2008/09, to 444 per 100,000 in 2019/20 (an increase of 39%). A Kent initiative urged residents to try the 'Know Your Score' online tool at www.kent.gov.uk/knowyourscore which asks 10 questions about drinking habits before giving users a score and information of where they can get support in Kent to help if they are consuming too much.

18.1.4 There is limited guidance and information on the treatment of co-occurring conditions. The NICE guidance[44] is clear that both mental health and substance use treatment services should support individuals' needs simultaneously, with mental health services taking the lead responsibility for assessment and care planning. Individuals should not be excluded from mental health, physical health, social care, housing or other support services because of co-occurring conditions. Commissioning advice published by Public Health England, sets out that commissioners and providers of mental health and drug and alcohol services have a joint responsibility to meet the needs of individuals with co-occurring conditions. This piece of work is already under way within Kent and Medway and the findings of this review should be used to support it.

18.1.5 The published briefing paper[45] on multiple disadvantage and co-occurring substance use and mental health conditions identifies a series of recommendations including those relating to accountability, local partnerships and commissioning. It is highly recommended that these are considered by agencies within Kent and Medway.

18.1.6 The issue of people with co-occurring conditions was also highlighted within a recent Kent and Medway DHR "Louise" where a recommendation was identified as - A good way forward will be a multi-agency seminar with key partners to discuss and explore alternative strategies and best practice to tackle this relatively small cohort of hard-to-reach people. These findings are also reflective of findings within similar SAR's. The findings within this review should also be reflected within that identified piece of work.

[44] https://www.nice.org.uk/guidance/ng58

[45] http://meam.org.uk/wp-content/uploads/2022/06/Co-occurring-conditions-briefing-FINAL-June-2022.pdf

	Recommendation	Organisation
1	KCC Integrated Children's Services are to remind their staff involved in CP Case Conferences and Core Group meetings to request attendance and reports from all agencies involved in the support planning process surrounding the child and significant family members, including GP and charities supporting the person i.e. substance misuse services.	KCC Integrated Children's Services
2a.	Better multiagency working, stronger provider led risk assessments and improved understanding and training for domestic abuse practitioners is required to help them better identify and support, in a non-stigmatising way, vulnerable people who are experiencing alcohol harm. This is an area that could benefit from improved multi-agency procedures. Consideration to be given to the recommendations identified in the above briefing paper referenced at 18.1.5 and also work taking place supporting people with co-occurring conditions.	Public Health
2b.	A multi-agency seminar with key partners is to be developed to discuss and explore alternative strategies and best practice to tackle this relatively small cohort of hard-to-reach people. The findings within this review should also be reflected within that identified piece of work. (as 18.1.6 above)	Public Health

18.2 The Family Environment and the Impact of Angela Moving Out of the Family Home

18.2.1 Few assessments were completed regarding the suitability of Joseph's family home either prior to the baby moving home with Angela or when Angela left. The home was reported as being overcrowded, smoky and with a family member managing terminal illness. Family members were relied upon to support Angela to care for her baby when services raised concerns around Angela's ability to keep her baby safe. ICS were aware that at this time Joseph was working nights and so Joseph's mother was identified as the support mechanism for Angela. This took place without any consideration regarding the relationship between Angela and Joseph's family and what impact this would have upon Angela. Angela would report to professionals that she was feeling isolated from the

family, and then later on she would say she felt supported. ICS did not consider whether Angela was being subjected to domestic abuse or coercive controlling behaviour from family members which would impact on the level of access she would have had to her baby and also the support she received.

18.2.2 The impact of Angela moving out of the family home was underestimated and although support was offered, this was not joined up. Angela was not identified as a person with care and support needs in her own right and the support provided to her mainly related to her baby. There was a heavy reliance upon Angela to self-refer to support agencies and there was no identified lead person. Angela had a long history of trauma in her personal life which was known to agencies but which was not considered.

	Recommendation	Organisation
3	Kent Integrated Children's Services to develop a 'spotlight on domestic abuse' series, a programme to develop knowledge in many aspects of domestic abuse, including coercive and controlling behaviour. It is recommended that this training programme be extended to include the link between domestic abuse and suicide and links in with the work already being undertaken by Public Health. Programme materials to be shared with other agencies. This piece of work is to link in with the Kent and Medway suicide prevention strategy which highlights the linkage between domestic abuse and suicide.	KCC Integrated Children's Services and KCHFT
4	Awareness raising forums to take place with professionals to highlight the heightened risk of suicide of a parent when children and parents are separated. To understand and support the parent including the management of risk and to identify suitable signposting, especially when a parent has other risks and has increased care and support needs.	KCC Integrated Children's Services and Adult Social Care, CCGs including Primary Care and KCHFT.
5a	Each agency needs to ensure that their frontline staff understands the difference between a safeguarding concern referral and a referral for care and support needs and also highlighting the importance of recording the rational of their decision making. The KMSAB to assure itself regarding the knowledge of agencies relating to the above referral process.	All agencies and KMSAB.

5b	Joint training to take place between ICS and ASC to highlight the crossover in services and the need to work more closely together. This training is to include ACEs and the Trauma Care approach.	ICS and ASCH

18.3 The Hostel

18.3.1 An information sharing agreement is in place between the police and Hostel B and evidence was received that this process was working well. The hostel was made aware of incidents surrounding Anthony when he was living at the hostel. It was however, identified that the information was not always passed to other agencies. Anthony was under the Probation Service during his time at the hostel however, the relevant information surrounding his sexualised behaviour was not shared with them by Anthony's hostel worker. Risk assessments can be an important part of assessing a person, however, can also become counterproductive if not used properly and the impact of the risk not appropriately considered.

	Recommendation	Organisation
6	Hostel B staff are to receive training in relation to completing dynamic Risk Assessments on residents to include viewing the individual from both a victim and a perpetrator perspective. Risk Assessments are to be updated on a three monthly basis and the impact of the risk identified to be carefully considered and what impact the risk has on the resident themselves and other people including staff and other residents. Risk assessments are to be shared with professionals supporting residents at the hostels.	Hostel B
7	All staff within Hostel B are to receive mandatory training in domestic abuse and coercive and controlling behaviour. To ensure that each hostel manager has the responsibility to access local available specialist support, including perpetrator programmes, with links locally for each of their services.	Hostel B

GLOSSARY

Abbreviations and acronyms are listed alphabetically. The explanation of terms used in the main body of the Overview Report are listed in the order that they first appear.

Abbreviation / Acronym	Expansion
AAFDA	Advocacy After Fatal Domestic Abuse
ACEs	Adverse Childhood Experiences
ARMS	Adult Referral Management System
ART	Active Review Team
ASC	Adult Social Care
BTP	British Transport Police
CCG	Clinical Commissioning Group
CGL	Change Grow Live
CiN	Children in Need
CMHT	Community Mental Health Team
CRHT	Crisis Resolution Home Treatment
CSP	Community Safety Partnership
DA	Domestic Abuse
DASH	Domestic Abuse, Stalking and Harassment (Risk Assessment)
DHR	Domestic Homicide Review
DNA	Did Not Attend
ED	Emergency Department
EHW	Early Help Worker
GP	General Practitioner
HV	Health Visitor
IAPT	Improving Access to Psychological Therapies
ICPC	Initial Child Protection Conference
ICS	Integrated Children's Services
IDVA	Independent Domestic Violence Advisor
IMR	Independent Management Report
KCHFT	Kent Community Health NHS Foundation Trust
KCSP	Kent Community Safety Partnership
KERS	Kent Enablement and Recovery Service
KMPT	Kent & Medway NHS & Social Care Partnership Trust

MAPPA	Multi-Agency Public Protection Arrangements
MARAC	Multi-Agency Risk Assessment Conference
MCA	Mental Capacity Act
MDT	Multi-Disciplinary Team
MH	Mental Health
MIMHS	Maternal and Infant Mental Health Services
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
OOH	Out Of Hours
RED	Risk, Evaluation and Decision
SAR	Safeguarding Adults Review
SARC	Sexual Assault Referral Centre
SPoA	Single Point of Access
SW	Social Worker
SWEP	Severe Weather Emergency Protocol

Domestic, Abuse, Stalking & Harassment (DASH) Risk Assessments

The DASH (2009) – Domestic Abuse, Stalking and Harassment and Honour-based Violence model was agreed by the Association of Chief Police Officers (ACPO) as the risk assessment tool for domestic abuse. A list of 29 pre-set questions will be asked of anyone reporting being a victim of domestic abuse, the answers to which are used to assist in determining the level of risk. The risk categories are as follows:

Standard Current evidence does not indicate the likelihood of causing serious harm.

Medium There are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances.

High There are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious. Risk of serious harm is a risk which is life threatening and/or traumatic, and from which recovery, whether physical or psychological, can be expected to be difficult or impossible.

In addition, the DASH includes additional question, asking the victim if the perpetrator constantly texts, calls, contacts, follows, stalks or harasses them. If the answer to this question is yes, further questions are asked about the nature of this. A copy of the DASH questionnaire can be viewed here.

Domestic Abuse (Definition)

The definition of domestic violence and abuse states:

Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:

- *psychological*
- *physical*
- *sexual*
- *financial*
- *emotional*

Controlling behaviour is:

> *a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.*

Coercive behaviour is:

> *an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.*

Multi-Agency Risk Assessment Conference (MARAC)

A MARAC is a meeting where information is shared between representations of relevant statutory and voluntary sector organisations about victims of domestic abuse who are at the greatest risk. Victims do not attend MARAC meetings; they are represented by their Independent Domestic Violence Advisor (IDVA).

There are thirteen established MARACs across the whole County which are facilitated by MARAC Coordinators employed by Kent Police. Kent Police also employ a MARAC Central Coordinator, who is responsible for ensuring that the MARACs provide a consistent level of support to high-risk domestic abuse victims. The Central Coordinator deputises for absent Administrators at MARAC meetings.

The Central Coordinator is also responsible for ensuring that the Kent and Medway MARAC Operating Protocol and Guidelines (OPG) are updated and that each MARAC adheres to them. A further responsibility of the Central Coordinator is to provide training for MARAC members and chairpersons.